Board of County Commissioners

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

PUBLIC HEARING AGENDA

NOTICE TO READERS: The Board of County Commissioners' meeting packets are prepared several days prior to the meeting. This information is reviewed and studied by the Board members to gain a basic understanding, thus eliminating lengthy discussions. Timely action and short discussion on agenda items does not reflect a lack of thought or analysis on the Board's part. An informational packet is available for public inspection in the Board's Office one day prior to the meeting.

THIS AGENDA IS SUBJECT TO CHANGE

Tuesday
September 1, 2020
9:30 AM

Watch the virtual meeting through our You Tube Channel
http://www.adcogov.org/events/bocc-public-hearing-9

1. **ROLL CALL**

2. **PLEDGE OF ALLEGIANCE**

3. **MOTION TO APPROVE AGENDA**

4. **AWARDS AND PRESENTATIONS**

   A. Proclamation of September 2020 as Workforce Awareness Month

5. **PUBLIC COMMENT**

   A. Citizen Communication

   Members of the public may submit written comments on any matter within the Board's subject matter jurisdiction or request to speak at the meeting through our eComment system at https://adcogov.legistar.com/Calendar.aspx

   Residents are encouraged to submit comments, prior to the meeting, through written comment using eComment; eComment is integrated with the published meeting agenda and individuals may review the agenda item details and indicate their position on each item. A request to speak at the meeting may also be submitted using the eComment feature. You will be prompted to set up a user profile to allow you to comment, which will become part of the official public record. The eComment period opens when the agenda is published and closes at 4:30 p.m. the Monday prior to the noticed meeting.

   B. Elected Officials' Communication

6. CONSENT CALENDAR

A. List of Expenditures Under the Dates of August 10-14, 2020

B. Minutes of the Commissioners' Proceedings from August 18, 2020

C. Resolution Approving Application in Case #PLT2019-00026; Ridgeview Estates Final Plat, Filing No. 1
(File approved by ELT)

D. Resolution Approving Application in Case #PLT2020-00018; JRJK Dream Acres Final Plat
(File approved by ELT)

E. Resolution Approving Case #SIA2019-00019 Subdivision Improvements Agreement for Ridgeview Estates, Filing No. 1
(File approved by ELT)

F. Resolution Accepting a Special Warranty Deed from Alfred J. Linnebur Flying J Service, Inc, to Adams County for Right-of-Way Dedication Purposes
(File approved by ELT)

G. Resolution for Approving the Flood Insurance Assessment and the Program for Public Information for Adams County
(File approved by ELT)

H. Resolution Appointing Hearing Officer to Hear Appeals before the Adams County Board of Equalization
(File approved by ELT)

I. Resolution Regarding Defense and Indemnification of Bradley Guildner as a Defendant Pursuant to C.R.S. § 24-10-101, Et Seq.
(File approved by ELT)

J. Resolution Approving Abatement Petitions and Authorizing the Refund Of Taxes for Account Numbers R0139133, P0034733, R0007009, R0162582, R0055160, R0188047, R0100719, R0077815, R0118564, R0064210, R0121751, R0147811, and R0175821
(File approved by ELT)

K. Resolution Appointing Hearing Officer to Hear Appeals before the Adams County Board of Equalization
(File approved by ELT)

L. Resolution Approving Right-of-Way Agreement between Adams County and Clear Creek Station Metropolitan District No. 1 for Property Necessary for the Traffic Signal Cabinet Upgrade Project
(File approved by ELT)

M. Resolution Approving Adams County Scientific and Cultural Facilities District Funding Distribution Plan for 2020-2021
(File approved by ELT)

N. Resolution to Adopt Delta Dental Benefits Contracts
(File approved by ELT)

O. Resolution Adopting Amendments to Adams County's Group Agreements with Kaiser Permanente
(File approved by ELT)

P. Resolution Adopting Amendments to Adams County's Contracts with United Healthcare Services
(File approved by ELT)

Q. Resolution Adopting Amendment No. 4 to the Unum Group Disability Insurance Policy and Amendment No. 8 and Amendment No. 9 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Policy
(File approved by ELT)

R. A Resolution Calling an Election on November 3, 2020 to Authorize the Permanent Extension of an Existing Countywide Sales Tax of One-Fourth of One Percent (One-Fourth Penny per Dollar for the Continued Purpose of Preserving Open Space and Creating and Maintaining Parks and Recreation Facilities; Setting the Ballot Title and Text for the Election; and Providing the Effective Date of Such Resolution
(File approved by ELT)

S. A Resolution Calling an Election on November 3, 2020 to Authorize the Permanent Extension of an Existing Countywide Sales Tax of One-Half Percent (One-Half Penny per Dollar) for the Continuing Purpose of Improvements to or the Building of Road and Bridge Projects and the Continuing Purpose of Constructing, Acquiring, Equipping, Operating, Maintaining and Expanding Existing and New Adams County Government Facilities; A Portion of which Shall Continue to be Shared with the Incorporated Cities and Towns in Adams County; Setting the Ballot Title and Text of the Ballot Issue for the Election; and Providing the Effective Date of Such Resolution
(File approved by ELT)

T. A Resolution Referring to the Registered Electors of Adams County, at the November 3, 2020 General Election, the Question of Whether the Term Limits for the Office of Adams County Coroner Should be Eliminated so that the Coroner is Allowed to Serve the Residents of Adams County, for as Long as the Voters of Adams County Choose to Re-Elect Him/Her, as Authorized by Article XVIII Section 11(2) of the Colorado Constitution; Setting the Ballot Title and the Ballot Text of the Ballot Question for the Election; and Providing the Effective Date of Such Resolution
(File approved by ELT)

U. Resolution Correcting and Restating the Resolution Approving of Application in Case #PRC2019-00013 McCarty and Heinz Acres
(File approved by ELT)

V. Resolution Approving Intergovernmental Agreement between the Board of County Commissioners of the County of Adams and Southeast Weld Fire Protection District Regarding Disbursement of Coronavirus Aid, Relief and Economic Security Act Funds
(File approved by ELT)

W. Resolution Approving Intergovernmental Agreement between the Board of County Commissioners of the County of Adams and Sable-Altura Fire Rescue District Regarding Disbursement of Coronavirus Aid, Relief and Economic Security Act Funds
(File approved by ELT)

X. Resolution Approving Agreement between the Board of County Commissioners of the County of Adams and Colorado Legal Services Regarding Disbursement of Coronavirus Aid, Relief and Economic Security Act Funds
(File approved by ELT)

7. NEW BUSINESS

A. COUNTY MANAGER

1. Resolution Approving an Agreement between Adams County and JCOR Mechanical, Inc., for the Detention Facility Module "B" Sanitary Sewer Replacement
(File approved by ELT)

B. COUNTY ATTORNEY

8. LAND USE HEARINGS

A. Cases to be Heard

1. RCU2020-00004 Pioneer Produced Water Pipeline
(File approved by ELT)

2. PRC2019-00012 Rocky Mountain Rail Park
(File approved by ELT)

3. PRC2019-00020 Brannan Sand and Gravel
(File approved by ELT)

9. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

Proclamation

"Workforce Awareness Month"
September 2020

Whereas, September is Workforce Awareness Month and calls attention to the fact that the Workforce and Business Center has served nearly 13,500 residents resulting in over 25 million dollars in wages impacting the local economy; and

Whereas, in Adams County, business is booming with the county projected to grow employment 165% higher than the rest of the country over the next five years, and our economy has made us a magnet for employers and one of the best performing states in the nation; and

Whereas, with the average number of unemployed persons during the time period at 8,800, nearly 7,900 participants were employed within six months of utilizing program services; and

Whereas, apprenticeships, internships, and experiential learning are proven strategies to close the skills gap, build self-esteem, and develop an alternative pathway to a rewarding career; and

Whereas, the careers of tomorrow require a job-driven approach to ensure that a talent pipeline of qualified workers is in place; and

Whereas, when workers, students, educators, workforce professionals, and employers are united in addressing the challenges that lay ahead, and no one is shut out or left behind, Adams County can become the best county in Colorado to gain employment; and

Whereas, Adams County residents are encouraged to celebrate the diversity of our workforce and commit ourselves to ensuring that Colorado workplaces are inclusive to all qualified workers; and

Whereas, the Adams County Workforce Development Board is aligned with educators, businesses, and economic developers to enhance regional workforce development, expand apprenticeships, encourage more inclusive hiring, and promote the state's competitive advantage.

Now, Therefore, Be It Resolved That, the Board of Commissioners of the County of Adams, State of Colorado, proclaims the month of September 2020 as

"Workforce Awareness Month"

In witness whereof, we have set our hands and caused the seal of the county to be affixed September 1, 2020.

County of Adams

Net Warrant by Fund Summary

Fund Number	Fund Description	Amount
1	General Fund	872,458.52
4	Capital Facilities Fund	1,833,147.95
5	Golf Course Enterprise Fund	95,165.02
6	Equipment Service Fund	317,050.83
13	Road & Bridge Fund	307,530.79
19	Insurance Fund	300.00
25	Waste Management Fund	807,930.11
27	Open Space Projects Fund	3,837.65
28	Open Space Sales Tax Fund	69,540.48
30	Community Dev Block Grant Fund	17,643.25
31	Head Start Fund	9,525.38
35	Workforce & Business Center	515.00
43	Colorado Air & Space Port	59,387.96
50	FLATROCK Facility Fund	5,710.75
		4,399,743.69

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006338	320719	DLR GROUP	8/11/2020	15,944.27
00006339	104910	SAUNDERS CONSTRUCTION INC	8/11/2020	319,097.31
00006353	519505	DENOVO VENTURES LLC	8/13/2020	5,020.00
00006355	1016895	G4S SECURE SOLUTIONS USA INC	8/13/2020	24,906.66
00006357	1054079	IMPACT CHARITABLE	8/13/2020	50,000.00
00006361	273765	UNITED POWER	8/13/2020	10,541.00
00751378	72554	AAA PEST PROS	8/13/2020	1,845.00
00751382	91631	ADAMSON POLICE PRODUCTS	8/13/2020	1,760.50
00751383	630412	ADVANCED LAUNDRY SYSTEMS	8/13/2020	1,343.47
00751385	888858	ALL RECYCLING INC	8/13/2020	755.10
00751390	140646	AZTEC SOFTWARE LLC	8/13/2020	2,500.00
00751391	105179	BALDWIN MARY	8/13/2020	150.00
00751392	46309	BELLCO	8/13/2020	300.00
00751393	3020	BENNETT TOWN OF	8/13/2020	1,500.00
00751394	3020	BENNETT TOWN OF	8/13/2020	79.05
00751395	1040417	BIRDSEED COLLECTIVE	8/13/2020	2,730.00
00751396	13160	BRIGHTON CITY OF (WATER)	8/13/2020	7,393.73
00751397	13160	BRIGHTON CITY OF (WATER)	8/13/2020	4,881.41
00751398	13160	BRIGHTON CITY OF (WATER)	8/13/2020	758.76
00751399	13160	BRIGHTON CITY OF (WATER)	8/13/2020	15,240.95
00751400	13160	BRIGHTON CITY OF (WATER)	8/13/2020	103.03
00751401	13160	BRIGHTON CITY OF (WATER)	8/13/2020	19,335.73
00751403	8973	C & R ELECTRICAL CONTRACTORS I	8/13/2020	761.08
00751404	726898	CA SHORT COMPANY	8/13/2020	3,650.00
00751405	1052912	CASTLE AND CASTLE	8/13/2020	2.50
00751406	37266	CENTURY LINK	8/13/2020	85.00
00751411	1044026	CHAINSAWMAMA LLC	8/13/2020	4,995.00
00751413	112904	CHRISTIAN VICKI	8/13/2020	150.00
00751419	80146	COLO DEPT OF PUBLIC HEALTH & E	8/13/2020	250.00
00751420	99357	COLO MEDICAL WASTE INC	8/13/2020	1,949.00
00751421	209334	COLO NATURAL GAS INC	8/13/2020	28.76
00751422	636100	COLOR CORRAL	8/13/2020	2,370.10
00751423	612089	COMMERCIAL CLEANING SYSTEMS	8/13/2020	102,369.27
00751426	255001	COPYCO QUALITY PRINTING INC	8/13/2020	5,500.00
00751429	44656	DENVER HEALTH & HOSPITAL AUTHO	8/13/2020	680.00
00751433	691812	EXTREME TOWING & RECOVERY SERV	8/13/2020	250.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751435	289826	FASTENAL COMPANY	8/13/2020	392.75
00751436	47723	FEDEX	8/13/2020	128.90
00751437	2963	FEY TOM E	8/13/2020	150.00
00751440	1054474	FORT COLLINS POLICE SERVICES	8/13/2020	56.00
00751441	671123	FOUND MY KEYS	8/13/2020	2,142.40
00751442	1054482	GALDEAN ALEJANDRO	8/13/2020	19.00
00751443	12689	GALLS LLC	8/13/2020	29,257.45
00751444	783632	GAM ENTERPRISES INC	8/13/2020	3,293.84
00751446	1054674	GAUGLER MARISSA	8/13/2020	2,500.00
00751447	808845	GRONQUIST CHRIS	8/13/2020	65.00
00751451	809485	HAGGERTY BRIAN	8/13/2020	65.00
00751452	890715	HALLIDAY WATKINS AND MANN	8/13/2020	143.00
00751457	32276	INSIGHT PUBLIC SECTOR	8/13/2020	7,358.39
00751458	13565	INTERMOUNTAIN REA	8/13/2020	26.02
00751459	198956	INTERVET INC	8/13/2020	1,950.00
00751461	1052516	JACKSON JASPER	8/13/2020	120.00
00751463	859588	JAZOWSKI KAREN	8/13/2020	1,750.00
00751465	77611	KD SERVICE GROUP	8/13/2020	254.50
00751466	145356	KENNY ELECTRIC SERVICE INC	8/13/2020	216.00
00751467	1029848	KING SOOPERS	8/13/2020	150.00
00751471	1020086	LABORATORY CORPORATION OF AMER	8/13/2020	8,900.00
00751473	40843	LANGUAGE LINE SERVICES	8/13/2020	1,301.34
00751475	1029309	LIBERTY UNIVERSITY INC	8/13/2020	1,338.75
00751476	799360	LIMA PEDRO F	8/13/2020	1,175.24
00751477	1054895	LOWRY SAM	8/13/2020	150.00
00751478	1054479	LOYA OLIVIA	8/13/2020	19.00
00751480	797973	MARKET STREET MANAGEMENT LLC	8/13/2020	19,499.00
00751483	637831	MCCREARY RAPHAEL	8/13/2020	65.00
00751484	51274	MCDONALD YONG HUI V	8/13/2020	4,791.06
00751488	93018	MURPHY RICK	8/13/2020	3,429.74
00751489	13591	MWI VETERINARY SUPPLY CO	8/13/2020	15.64
00751490	32509	NCS PEARSON INC	8/13/2020	66.50
00751491	1052102	NEAL ROBERT	8/13/2020	75.00
00751493	59978	NORTH COLORADO MEDICAL CTR	8/13/2020	621.00
00751494	13774	NORTH PECOS WATER & SANITATION	8/13/2020	41.13
00751495	1029852	NORTH SUBURBAN MEDICAL CENTER	8/13/2020	100.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751496	13422	NORTHGLENN AMBULANCE	8/13/2020	96.60
00751497	1004574	OCHS CRYSTAL	8/13/2020	710.00
00751498	1054478	ODEGARD CHERYL ANN	8/13/2020	19.00
00751499	949999	OFFICESCAPES OF DENVER LLLP	8/13/2020	18,734.55
00751500	282112	ORACLE AMERICA INC	8/13/2020	6,871.53
00751502	12691	PEARL COUNSELING ASSOCIATES	8/13/2020	6,377.00
00751504	176327	PITNEY BOWES GLOBAL FINANCIAL	8/13/2020	1,239.21
00751510	1054131	RUSCH APRIL	8/13/2020	100.00
00751511	472626	SAFEWARE INC	8/13/2020	6,423.37
00751512	1054475	SALAZAR MA TRINIDAD	8/13/2020	66.00
00751514	1029870	SANTIAGOS MEXICAN RESTURANT	8/13/2020	100.00
00751515	13932	SOUTH ADAMS WATER & SANITATION	8/13/2020	1,235.76
00751517	51001	SOUTHLAND MEDICAL LLC	8/13/2020	593.31
00751520	686895	STOGSDILL SHANNA	8/13/2020	1,039.50
00751521	13949	STRASBURG SANITATION	8/13/2020	1,537.80
00751523	599714	SUMMIT FOOD SERVICE LLC	8/13/2020	42,546.36
00751524	293662	SUMMIT LABORATORIES INC	8/13/2020	480.00
00751526	1047964	SYMMETRY ENERGY SOLUTIONS LLC	8/13/2020	13,513.40
00751528	498722	THERMAL & MOISTURE PROTECTION	8/13/2020	450.00
00751530	319978	TONSAGER DENNIS	8/13/2020	65.00
00751531	810316	TRELOAR TARA A	8/13/2020	65.00
00751532	666214	TYGRETT DEBRA R	8/13/2020	120.00
00751533	1035011	U-HAUL CREDIT ADMINISTRATION	8/13/2020	25.00
00751534	1007	UNITED POWER (UNION REA)	8/13/2020	4,785.02
00751556	51179	UPS	8/13/2020	31.22
00751557	296691	US POSTAL SERVICE	8/13/2020	240.00
00751558	1029885	US VENTURE	8/13/2020	150.00
00751560	1040418	VEIGA BRASIL III RICHARD A	8/13/2020	2,730.00
00751562	1052515	WALMART	8/13/2020	283.12
00751563	46796	WESTMINSTER CITY OF	8/13/2020	9,977.69
00751565	712817	WHITESTONE CONSTRUCTION SERVIC	8/13/2020	7,125.00
00751566	18645	WILBUR-ELLIS COMPANY LLC	8/13/2020	3,505.00
00751567	702804	WOLFE SANDRA KAY	8/13/2020	65.00
00751568	1054481	WOODARD MATTHEW	8/13/2020	19.00
00751569	338508	WRIGHTWAY INDUSTRIES INC	8/13/2020	660.24
00751570	13822	XCEL ENERGY	8/13/2020	69.76

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751571	13822	XCEL ENERGY	8/13/2020	12,466.96
00751572	13822	XCEL ENERGY	8/13/2020	677.19
00751573	13822	XCEL ENERGY	8/13/2020	82.94
00751574	13822	XCEL ENERGY	8/13/2020	82.91
00751575	13822	XCEL ENERGY	8/13/2020	835.54
00751576	13822	XCEL ENERGY	8/13/2020	44.99
00751577	13822	XCEL ENERGY	8/13/2020	44.59
00751578	13822	XCEL ENERGY	8/13/2020	46.17
00751579	13822	XCEL ENERGY	8/13/2020	74.31
00751580	13822	XCEL ENERGY	8/13/2020	79.84
00751581	13822	XCEL ENERGY	8/13/2020	52.51
00751582	13822	XCEL ENERGY	8/13/2020	84.29
00751583	13822	XCEL ENERGY	8/13/2020	56.20
00751584	13822	XCEL ENERGY	8/13/2020	45.93
00751585	13822	XCEL ENERGY	8/13/2020	66.08
00751586	13822	XCEL ENERGY	8/13/2020	44.60
00751587	13822	XCEL ENERGY	8/13/2020	406.87
00751588	13822	XCEL ENERGY	8/13/2020	16.04
00751589	13822	XCEL ENERGY	8/13/2020	3,948.00
00751590	13822	XCEL ENERGY	8/13/2020	68.82
00751591	13822	XCEL ENERGY	8/13/2020	1,234.29
00751592	13822	XCEL ENERGY	8/13/2020	6,742.36
00751593	13822	XCEL ENERGY	8/13/2020	11,634.94
00751594	13822	XCEL ENERGY	8/13/2020	618.73
00751595	13822	XCEL ENERGY	8/13/2020	100.65
			Fund Total	**872,458.52**

4 Capital Facilities Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006340	104910	SAUNDERS CONSTRUCTION INC	8/11/2020	1,419,083.98
00006360	908009	TAYLOR KOHRS LLC	8/13/2020	296,687.12
00006363	40847	WORKPLACE ELEMENTS	8/13/2020	11,037.46
00751427	798606	D2C ARCHITECTS INC	8/13/2020	31,353.16
00751448	12812	GROUND ENGINEERING CONSULTANTS	8/13/2020	666.50
00751474	35643	LARSON RICHARD E	8/13/2020	918.04
00751479	734988	LYNXWILER ART & DESIGN	8/13/2020	18,000.00
00751503	39496	PIPER COMMUNICATION SERVICES I	8/13/2020	5,122.00
00751509	248870	ROTH SHEPPARD ARCHITECTS	8/13/2020	19,300.00
00751518	740359	STANTEC ARCHITECTURE INC	8/13/2020	25,403.19
00751529	498722	THERMAL & MOISTURE PROTECTION	8/13/2020	5,516.50
00751535	1007	UNITED POWER (UNION REA)	8/13/2020	20.00
00751536	1007	UNITED POWER (UNION REA)	8/13/2020	20.00
00751537	1007	UNITED POWER (UNION REA)	8/13/2020	20.00
			Fund Total	**1,833,147.95**

5 Golf Course Enterprise Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006358	6177	PROFESSIONAL RECREATION MGMT I	8/13/2020	21,357.35
00006359	6177	PROFESSIONAL RECREATION MGMT I	8/13/2020	65,790.28
00751379	72554	AAA PEST PROS	8/13/2020	45.00
00751384	8579	AGFINITY INC	8/13/2020	4,227.09
00751386	12012	ALSCO AMERICAN INDUSTRIAL	8/13/2020	54.36
00751402	9822	BUCKEYE WELDING SUPPLY CO INC	8/13/2020	30.60
00751470	11496	L L JOHNSON DIST	8/13/2020	2,219.76
00751481	308369	MASEK GOLF CARS OF COLORADO	8/13/2020	363.40
00751506	152295	POTESTIO BROTHER EQUIPMENT	8/13/2020	741.00
00751596	13822	XCEL ENERGY	8/13/2020	44.73
00751597	13822	XCEL ENERGY	8/13/2020	291.45
			Fund Total	**95,165.02**

6 Equipment Service Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751381	23962	ACS MANAGEMENT LLC	8/13/2020	4,554.00
00751388	979430	ASBURY CO CDJR LLC	8/13/2020	84,096.00
00751434	346750	FACTORY MOTOR PARTS	8/13/2020	8,344.21
00751453	729896	HOLLAND SIGNS INC	8/13/2020	17,661.00
00751456	682207	INSIGHT AUTO GLASS LLC	8/13/2020	396.78
00751468	5117	KOIS BROTHERS EQUIP CO	8/13/2020	57,720.00
00751482	44212	MCCANDLESS INTL TRUCKS OF COLO	8/13/2020	88,266.00
00751486	226709	MITCHELL1	8/13/2020	1,728.00
00751507	324769	PRECISE MRM LLC	8/13/2020	10,968.00
00751513	16237	SAM HILL OIL INC	8/13/2020	20,158.04
00751525	78870	SUN ENTERPRISES INC	8/13/2020	21,679.00
00751564	350373	WEX BANK	8/13/2020	1,479.80
			Fund Total	**317,050.83**

13 Road & Bridge Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006362	273765	UNITED POWER	8/13/2020	300.00
00751387	12012	ALSCO AMERICAN INDUSTRIAL	8/13/2020	191.17
00751415	43659	CINTAS FIRST AID & SAFETY	8/13/2020	223.13
00751416	1054102	CLASSIC II HOLDINGS LLC	8/13/2020	2,500.00
00751417	2305	COBITCO INC	8/13/2020	820.38
00751428	338740	DAVEY TREE EXPERT CO	8/13/2020	2,700.00
00751431	534975	EP&A ENVIROTAC INC	8/13/2020	35,644.18
00751432	873559	EST INC	8/13/2020	32,182.42
00751449	12812	GROUND ENGINEERING CONSULTANTS	8/13/2020	1,243.00
00751450	1052619	GUERRERO SIMON	8/13/2020	1,800.00
00751462	142892	JALISCO INTL INC	8/13/2020	188,838.02
00751485	21134	METECH RECYCLING	8/13/2020	504.05
00751501	1039227	ORIUX	8/13/2020	2,971.73
00751508	556555	PREMIER PORTABLES	8/13/2020	350.00
00751516	13932	SOUTH ADAMS WATER & SANITATION	8/13/2020	247.77
00751527	790907	THE GOODYEAR TIRE AND RUBBER C	8/13/2020	1,224.00
00751538	1007	UNITED POWER (UNION REA)	8/13/2020	23.16
00751539	1007	UNITED POWER (UNION REA)	8/13/2020	33.00
00751540	1007	UNITED POWER (UNION REA)	8/13/2020	16.50
00751541	1007	UNITED POWER (UNION REA)	8/13/2020	34.00
00751542	1007	UNITED POWER (UNION REA)	8/13/2020	88.49
00751543	1007	UNITED POWER (UNION REA)	8/13/2020	36.00
00751544	1007	UNITED POWER (UNION REA)	8/13/2020	16.50
00751545	1007	UNITED POWER (UNION REA)	8/13/2020	16.50
00751546	1007	UNITED POWER (UNION REA)	8/13/2020	33.00
00751547	1007	UNITED POWER (UNION REA)	8/13/2020	48.28
00751548	1007	UNITED POWER (UNION REA)	8/13/2020	20.00
00751549	1007	UNITED POWER (UNION REA)	8/13/2020	153.79
00751550	1007	UNITED POWER (UNION REA)	8/13/2020	118.52
00751551	1007	UNITED POWER (UNION REA)	8/13/2020	131.40
00751552	1007	UNITED POWER (UNION REA)	8/13/2020	41.05
00751553	1007	UNITED POWER (UNION REA)	8/13/2020	99.26
00751554	1007	UNITED POWER (UNION REA)	8/13/2020	48.28
00751555	1007	UNITED POWER (UNION REA)	8/13/2020	44.78
00751559	158184	UTILITY NOTIFICATION CENTER OF	8/13/2020	154.96
00751561	13082	W L CONTRACTORS INC	8/13/2020	6,697.42

13 Road & Bridge Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751598	13822	XCEL ENERGY	8/13/2020	79.72
00751599	13822	XCEL ENERGY	8/13/2020	74.68
00751600	13822	XCEL ENERGY	8/13/2020	60.24
00751601	13822	XCEL ENERGY	8/13/2020	222.58
00751602	13822	XCEL ENERGY	8/13/2020	93.54
00751603	13822	XCEL ENERGY	8/13/2020	22,595.26
00751604	13822	XCEL ENERGY	8/13/2020	4,573.01
00751605	13822	XCEL ENERGY	8/13/2020	111.07
00751606	13822	XCEL ENERGY	8/13/2020	51.20
00751607	13822	XCEL ENERGY	8/13/2020	74.75
			Fund Total	**307,530.79**

19 Insurance Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751439	986661	FIT SOLDIERS LLC	8/13/2020	300.00
			Fund Total	**300.00**

25 Waste Management Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751460	104743	IRON WOMAN CONSTRUCTION	8/13/2020	807,930.11
			Fund Total	**807,930.11**

27 Open Space Projects Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751522	266133	STREAM LANDSCAPE ARCHITECTURE	8/13/2020	3,824.76
00751608	13822	XCEL ENERGY	8/13/2020	12.89
			Fund Total	**3,837.65**

28 Open Space Sales Tax Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006354	270671	EAGLE CREEK METROPOLITAN DISTR	8/13/2020	69,540.48
			Fund Total	**69,540.48**

30 Community Dev Block Grant Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006356	1041087	HAMPTON INN BRIGHTON	8/13/2020	8,750.00
00751430	1041510	DENVER STAIR LTD	8/13/2020	5,600.00
00751492	1039211	NESTMAN AND ENG ORTHODONTICS L	8/13/2020	3,293.25
			Fund Total	**17,643.25**

31 Head Start Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751407	37266	CENTURY LINK	8/13/2020	142.31
00751408	37266	CENTURY LINK	8/13/2020	404.41
00751409	37266	CENTURY LINK	8/13/2020	149.93
00751410	327914	CESCO LINGUISTIC SERVICE INC	8/13/2020	120.00
00751412	166025	CHILDRENS HOSPITAL	8/13/2020	825.00
00751414	327250	CINTAS CORPORATION NO 2	8/13/2020	160.89
00751418	5078	COLO DEPT OF HUMAN SERVICES	8/13/2020	70.00
00751425	248029	COMMUNITY REACH CENTER FOUNDAT	8/13/2020	6,515.84
00751454	479165	IDEMIA IDENTITY & SECURITY USA	8/13/2020	49.50
00751455	479165	IDEMIA IDENTITY & SECURITY USA	8/13/2020	49.50
00751469	40323	L & N SUPPLY COMPANY INC	8/13/2020	1,038.00
			Fund Total	**9,525.38**

35 Workforce & Business Center

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751472	1053564	LAJARAZO JAMIE	8/13/2020	150.00
00751487	1053565	MUNOZ PARRA ANA P	8/13/2020	215.00
00751505	1053567	PORTILLO YOCELYN	8/13/2020	150.00
			Fund Total	**515.00**

43 Colorado Air & Space Port

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00006352	709816	CITY SERVICEVALCON LLC	8/13/2020	21,504.46
00751389	80118	AT&T CORP	8/13/2020	107.50
00751464	204737	JVIATION INC	8/13/2020	37,776.00
			Fund Total	**59,387.96**

50 FLATROCK Facility Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00751380	72554	AAA PEST PROS	8/13/2020	60.00
00751424	612089	COMMERCIAL CLEANING SYSTEMS	8/13/2020	1,606.87
00751438	430523	FIRE INSPECTION SERVICES LLC	8/13/2020	3,800.00
00751445	783632	GAM ENTERPRISES INC	8/13/2020	240.75
00751519	33604	STATE OF COLORADO	8/13/2020	3.13
			Fund Total	**5,710.75**

Grand Total	**4,399,743.69**

3164	Byers/Shamrock Blade Stations	Fund	Voucher	Batch No	GL Date	Amount
	Buildings					
	GROUND ENGINEERING CONSULTANTS	00004	979671	370843	8/10/2020	666.50
					Account Total	666.50
					Department Total	666.50

4	Capital Facilities Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	D2C ARCHITECTS INC	00004	979950	371146	8/13/2020	1,603.16
	D2C ARCHITECTS INC	00004	979885	371146	8/13/2020	19,500.00
	D2C ARCHITECTS INC	00004	979885	371146	8/13/2020	10,250.00
	LYNXWILER ART & DESIGN	00004	979935	371146	8/13/2020	18,000.00
	ROTH SHEPPARD ARCHITECTS	00004	979898	371146	8/13/2020	19,300.00
	SAUNDERS CONSTRUCTION INC	00004	979713	370941	8/11/2020	1,419,083.98
	STANTEC ARCHITECTURE INC	00004	979874	371146	8/13/2020	17,358.49
	STANTEC ARCHITECTURE INC	00004	979875	371146	8/13/2020	8,044.70
	TAYLOR KOHRS LLC	00004	979850	371064	8/12/2020	312,302.23
	THERMAL & MOISTURE PROTECTION	00004	979873	371146	8/13/2020	5,354.25
	THERMAL & MOISTURE PROTECTION	00004	979873	371146	8/13/2020	162.25
	WORKPLACE ELEMENTS	00004	980008	371151	8/13/2020	11,037.46
					Account Total	1,841,996.52
	Retainages Payable					
	TAYLOR KOHRS LLC	00004	979850	371064	8/12/2020	15,615.11-
					Account Total	15,615.11-
					Department Total	1,826,381.41

9263	CARES Act Funding	Fund	Voucher	Batch No	GL Date	Amount
	Janitorial Services					
	COMMERCIAL CLEANING SYSTEMS	00001	979657	370839	8/10/2020	960.00
	COMMERCIAL CLEANING SYSTEMS	00001	979658	370839	8/10/2020	400.00
					Account Total	1,360.00
	Software and Licensing					
	AZTEC SOFTWARE LLC	00001	979451	370488	8/5/2020	2,500.00
					Account Total	2,500.00
					Department Total	3,860.00

4302	CASP Administration	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	AT&T CORP	00043	979817	371054	8/12/2020	93.22
					Account Total	93.22
					Department Total	93.22

4308	CASP ATCT	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	AT&T CORP	00043	979817	371054	8/12/2020	7.14
					Account Total	7.14
					Department Total	7.14

4304	CASP Operations/Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	AT&T CORP	00043	979817	371054	8/12/2020	7.14
					Account Total	7.14
					Department Total	7.14

941018	CDBG 2018/2019	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Inst.-Pgm. Cst					
	DENVER STAIR LTD	00030	979450	370506	8/5/2020	5,600.00
	HAMPTON INN BRIGHTON	00030	979343	370214	7/31/2020	8,750.00
	NESTMAN AND ENG ORTHODONTICS L	00030	979342	370211	7/31/2020	3,293.25
					Account Total	17,643.25
					Department Total	17,643.25

1022	CLK Elections	Fund	Voucher	Batch No	GL Date	Amount
	Subscrip/Publications					
	US POSTAL SERVICE	00001	979378	370348	8/4/2020	240.00
					Account Total	240.00
					Department Total	240.00

43	Colorado Air & Space Port	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	CITY SERVICEVALCON LLC	00043	979848	371061	8/12/2020	21,504.46
	JVIATION INC	00043	979879	371146	8/13/2020	37,776.00
					Account Total	59,280.46
					Department Total	59,280.46

2031	County Coroner	Fund	Voucher	Batch No	GL Date	Amount
	Education & Training					
	LIBERTY UNIVERSITY INC	00001	979454	370514	8/5/2020	1,338.75
					Account Total	1,338.75
	Operating Supplies					
	SOUTHLAND MEDICAL LLC	00001	979699	370931	8/11/2020	593.31
					Account Total	593.31
	Other Professional Serv					
	COLO MEDICAL WASTE INC	00001	979695	370931	8/11/2020	1,949.00
	FEDEX	00001	979698	370931	8/11/2020	128.90
	JAZOWSKI KAREN	00001	979684	370927	8/11/2020	1,750.00
	LABORATORY CORPORATION OF AMER	00001	979697	370931	8/11/2020	8,900.00
	LANGUAGE LINE SERVICES	00001	979701	370931	8/11/2020	100.86
	OCHS CRYSTAL	00001	979455	370514	8/5/2020	710.00
	UPS	00001	979690	370931	8/11/2020	31.22
					Account Total	13,569.98
					Department Total	15,502.04

6	Equipment Service Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ACS MANAGEMENT LLC	00006	979971	371146	8/13/2020	4,212.00
	ASBURY CO CDJR LLC	00006	979975	371146	8/13/2020	28,032.00
	ASBURY CO CDJR LLC	00006	979976	371146	8/13/2020	28,032.00
	ASBURY CO CDJR LLC	00006	979969	371146	8/13/2020	28,032.00
	FACTORY MOTOR PARTS	00006	979972	371146	8/13/2020	8,344.21
	HOLLAND SIGNS INC	00006	979955	371146	8/13/2020	17,661.00
	INSIGHT AUTO GLASS LLC	00006	979895	371146	8/13/2020	40.00
	INSIGHT AUTO GLASS LLC	00006	979973	371146	8/13/2020	162.14
	INSIGHT AUTO GLASS LLC	00006	979979	371146	8/13/2020	194.64
	KOIS BROTHERS EQUIP CO	00006	979970	371146	8/13/2020	57,720.00
	MCCANDLESS INTL TRUCKS OF COLO	00006	979977	371146	8/13/2020	88,266.00
	PRECISE MRM LLC	00006	979871	371146	8/13/2020	5,496.00
	PRECISE MRM LLC	00006	979974	371146	8/13/2020	5,472.00
	SAM HILL OIL INC	00006	979978	371146	8/13/2020	1,527.05
	SAM HILL OIL INC	00006	979896	371146	8/13/2020	14,937.45
	SAM HILL OIL INC	00006	979938	371146	8/13/2020	2,098.83
	SAM HILL OIL INC	00006	979939	371146	8/13/2020	1,594.71
	SUN ENTERPRISES INC	00006	979948	371146	8/13/2020	21,679.00
	WEX BANK	00006	979937	371146	8/13/2020	1,479.80
					Account Total	314,980.83
					Department Total	314,980.83

50	FLATROCK Facility Fund	Fund	Voucher	Batch No	GL Date	Amount
	Colorado Sales Tax Payable					
	STATE OF COLORADO	00050	979849	371062	8/12/2020	3.21
					Account Total	3.21
	Received not Vouchered Clrg					
	AAA PEST PROS	00050	979883	371146	8/13/2020	60.00
	COMMERCIAL CLEANING SYSTEMS	00050	979960	371146	8/13/2020	1,606.87
	GAM ENTERPRISES INC	00050	979945	371146	8/13/2020	240.75
					Account Total	1,907.62
					Department Total	1,910.83

9114	Fleet - Commerce City	Fund	Voucher	Batch No	GL Date	Amount
	Software and Licensing					
	MITCHELL1	00006	979600	370629	8/6/2020	1,728.00
					Account Total	1,728.00
	Vehicle Parts & Supplies					
	ACS MANAGEMENT LLC	00006	979601	370629	8/6/2020	342.00
					Account Total	342.00
					Department Total	2,070.00

1076	FO - Adams County Svc Center	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10874	00001	979474	370581	7/24/2020	12,466.96
	Energy Cap Bill ID=10888	00001	979639	370830	6/25/2020	314.02
	Energy Cap Bill ID=10900	00001	979745	371023	7/28/2020	62.23
					Account Total	12,843.21
					Department Total	12,843.21

1091	FO - Administration	Fund	Voucher	Batch No	GL Date	Amount
	Building Rental					
	BENNETT TOWN OF	00001	979656	370839	8/10/2020	1,500.00
					Account Total	1,500.00
	Gas & Electricity					
	Energy Cap Bill ID=10866	00001	979478	370581	7/20/2020	28.76
	Energy Cap Bill ID=10871	00001	979479	370581	7/20/2020	82.94
	Energy Cap Bill ID=10877	00001	979480	370581	7/23/2020	82.91
	Energy Cap Bill ID=10879	00001	979481	370581	7/22/2020	835.54
					Account Total	1,030.15
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10894	00001	979748	371023	8/1/2020	79.05
					Account Total	79.05
					Department Total	2,609.20

1114	FO - District Attorney Bldg.	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	C & R ELECTRICAL CONTRACTORS I	00001	979815	371055	8/12/2020	761.08
					Account Total	761.08
	Gas & Electricity					
	Energy Cap Bill ID=10873	00001	979490	370581	7/24/2020	56.20
					Account Total	56.20
					Department Total	817.28

2090	FO - Flatrock Facility	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	FIRE INSPECTION SERVICES LLC	00050	979816	371055	8/12/2020	3,800.00
					Account Total	3,800.00
	Gas & Electricity					
	Energy Cap Bill ID=10876	00050	979492	370581	7/24/2020	66.08
	Energy Cap Bill ID=10883	00050	979493	370581	7/24/2020	44.60
					Account Total	110.68
					Department Total	3,910.68

1077	FO - Government Center	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10884	00001	979475	370581	7/23/2020	677.19
					Account Total	677.19
	Maintenance Contracts					
	SUMMIT LABORATORIES INC	00001	979659	370839	8/10/2020	480.00
					Account Total	480.00
	Repair & Maint Supplies					
	FASTENAL COMPANY	00001	979813	371055	8/12/2020	216.57
	FASTENAL COMPANY	00001	979814	371055	8/12/2020	176.18
					Account Total	392.75
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10863	00001	979476	370581	7/16/2020	7,393.73
					Account Total	7,393.73
					Department Total	8,943.67

1070	FO - Honnen/Plan&Devel/MV Ware	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10878	00001	979469	370581	7/23/2020	69.76
	Energy Cap Bill ID=10904	00001	979739	371023	7/24/2020	3,948.00
	Energy Cap Bill ID=10905	00001	979740	371023	7/24/2020	68.82
	Energy Cap Bill ID=10910	00001	979741	371023	7/1/2020	1,234.29
					Account Total	5,320.87
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10869	00001	979470	370581	7/20/2020	1,235.76
					Account Total	1,235.76
					Department Total	6,556.63

1079	FO - Human Services Center	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10907	00001	979746	371023	7/29/2020	11,634.94
	Energy Cap Bill ID=10908	00001	979747	371023	7/28/2020	618.73
					Account Total	12,253.67
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10870	00001	979477	370581	7/16/2020	5,210.84
					Account Total	5,210.84
					Department Total	17,464.51

1071	FO - Justice Center	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10891	00001	979638	370830	6/25/2020	1,027.64
	Energy Cap Bill ID=10901	00001	979742	371023	7/28/2020	949.22
					Account Total	1,976.86
					Department Total	1,976.86

1069	FO - Old Animal Shelter	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10889	00001	979637	370830	6/25/2020	444.52
	Energy Cap Bill ID=10902	00001	979738	371023	7/28/2020	293.98
					Account Total	738.50
					Department Total	738.50

1067	FO - Old Human Service Bldg	Fund	Voucher	Batch No	GL Date	Amount
	Other Repair & Maint					
	MARKET STREET MANAGEMENT LLC	00001	979655	370839	8/10/2020	19,499.00
					Account Total	19,499.00
					Department Total	19,499.00

1111	FO - Parks Facilities	Fund	Voucher	Batch No	GL Date	Amount
	Buildings					
	LARSON RICHARD E	00001	979660	370839	8/10/2020	918.04
	UNITED POWER	00001	979651	370836	8/10/2020	10,541.00
	UNITED POWER (UNION REA)	00001	979652	370839	8/10/2020	20.00
	UNITED POWER (UNION REA)	00001	979653	370839	8/10/2020	20.00
	UNITED POWER (UNION REA)	00001	979654	370839	8/10/2020	20.00
					Account Total	11,519.04
	Gas & Electricity					
	Energy Cap Bill ID=10864	00001	979482	370581	7/6/2020	4,785.02
	Energy Cap Bill ID=10872	00001	979483	370581	7/23/2020	44.99
	Energy Cap Bill ID=10881	00001	979484	370581	7/23/2020	44.59
	Energy Cap Bill ID=10882	00001	979485	370581	7/23/2020	46.17
	Energy Cap Bill ID=10885	00001	979486	370581	7/23/2020	74.31
	Energy Cap Bill ID=10886	00001	979487	370581	7/23/2020	79.84
	Energy Cap Bill ID=10887	00001	979488	370581	7/23/2020	52.51
	Energy Cap Bill ID=10906	00001	979749	371023	7/28/2020	100.65
					Account Total	5,228.08
					Department Total	16,747.12

1112	FO - Sheriff HQ/Coroner Bldg	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10880	00001	979489	370581	7/23/2020	84.29
					Account Total	84.29
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10898	00001	979750	371023	7/28/2020	4,881.41
	Energy Cap Bill ID=10899	00001	979751	371023	7/28/2020	758.76
					Account Total	5,640.17
					Department Total	5,724.46

2009	FO - Sheriff Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10875	00001	979491	370581	7/23/2020	45.93
	Energy Cap Bill ID=10890	00001	979640	370830	6/25/2020	6,403.82
	Energy Cap Bill ID=10903	00001	979752	371023	7/28/2020	4,017.97
					Account Total	10,467.72
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10895	00001	979753	371023	7/28/2020	15,240.95
	Energy Cap Bill ID=10896	00001	979754	371023	7/28/2020	103.03
	Energy Cap Bill ID=10897	00001	979755	371023	7/28/2020	19,335.73
					Account Total	34,679.71
					Department Total	45,147.43

1075	FO - Strasburg/Whittier	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10867	00001	979473	370581	7/21/2020	26.02
					Account Total	26.02
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10893	00001	979744	371023	7/31/2020	1,537.80
					Account Total	1,537.80
					Department Total	1,563.82

1072	FO - West Services Center	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=10909	00001	979743	371023	7/29/2020	6,742.36
					Account Total	6,742.36
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=10865	00001	979471	370581	7/16/2020	3,955.02
	Energy Cap Bill ID=10868	00001	979472	370581	7/16/2020	811.83
					Account Total	4,766.85
					Department Total	11,509.21

3098	General Capital Improvements	Fund	Voucher	Batch No	GL Date	Amount
	Buildings					
	PIPER COMMUNICATION SERVICES I	00004	979670	370843	8/10/2020	5,122.00
					Account Total	5,122.00
					Department Total	5,122.00

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	Diversion Restitution Payable					
	BELLCO	00001	979777	371034	8/12/2020	300.00
	JACKSON JASPER	00001	979778	371034	8/12/2020	120.00
	KING SOOPERS	00001	979779	371034	8/12/2020	150.00
	NEAL ROBERT	00001	979774	371034	8/12/2020	75.00
	NORTH SUBURBAN MEDICAL CENTER	00001	979780	371034	8/12/2020	100.00
	RUSCH APRIL	00001	979776	371034	8/12/2020	100.00
	SANTIAGOS MEXICAN RESTURANT	00001	979781	371034	8/12/2020	100.00
	U-HAUL CREDIT ADMINISTRATION	00001	979783	371034	8/12/2020	25.00
	US VENTURE	00001	979786	371034	8/12/2020	150.00
	WALMART	00001	979775	371034	8/12/2020	283.12
					Account Total	1,403.12
	Received not Vouchered Clrg					
	AAA PEST PROS	00001	979967	371146	8/13/2020	65.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	120.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	60.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	145.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	120.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	50.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	85.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	150.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	140.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	160.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	310.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	55.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	60.00
	AAA PEST PROS	00001	979967	371146	8/13/2020	325.00
	ADAMSON POLICE PRODUCTS	00001	979980	371146	8/13/2020	1,116.00
	ADAMSON POLICE PRODUCTS	00001	979981	371146	8/13/2020	574.55
	ADAMSON POLICE PRODUCTS	00001	979982	371146	8/13/2020	69.95
	ADVANCED LAUNDRY SYSTEMS	00001	980003	371146	8/13/2020	1,343.47
	ALL RECYCLING INC	00001	979987	371146	8/13/2020	385.20
	ALL RECYCLING INC	00001	979988	371146	8/13/2020	369.90
	BIRDSEED COLLECTIVE	00001	979964	371146	8/13/2020	2,730.00
	CA SHORT COMPANY	00001	979876	371146	8/13/2020	3,650.00

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	CHAINSAWMAMA LLC	00001	979965	371146	8/13/2020	4,995.00
	COMMERCIAL CLEANING SYSTEMS	00001	979957	371146	8/13/2020	385.20
	COMMERCIAL CLEANING SYSTEMS	00001	979958	371146	8/13/2020	1,209.10
	COMMERCIAL CLEANING SYSTEMS	00001	979958	371146	8/13/2020	10,368.30
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	7,720.86
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	4,756.87
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	493.03
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	801.73
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	809.73
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	495.21
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	3,413.66
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	1,554.28
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	21,297.13
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	678.63
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	936.75
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	30,736.84
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	1,915.76
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	927.29
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	4,971.36
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	491.59
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	171.20
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	1,821.48
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	4,326.73
	COMMERCIAL CLEANING SYSTEMS	00001	979959	371146	8/13/2020	726.54
	COPYCO QUALITY PRINTING INC	00001	980001	371146	8/13/2020	5,500.00
	DENOVO VENTURES LLC	00001	979997	371151	8/13/2020	5,020.00
	DLR GROUP	00001	979710	370941	8/11/2020	6,809.27
	DLR GROUP	00001	979710	370941	8/11/2020	9,135.00
	EXTREME TOWING & RECOVERY SERV	00001	979989	371146	8/13/2020	250.00
	FOUND MY KEYS	00001	979993	371146	8/13/2020	721.00
	FOUND MY KEYS	00001	979994	371146	8/13/2020	1,421.40
	G4S SECURE SOLUTIONS USA INC	00001	980002	371151	8/13/2020	1,434.83
	G4S SECURE SOLUTIONS USA INC	00001	980004	371151	8/13/2020	1,434.83
	G4S SECURE SOLUTIONS USA INC	00001	980006	371151	8/13/2020	1,418.70
	G4S SECURE SOLUTIONS USA INC	00001	980000	371151	8/13/2020	1,434.83
	G4S SECURE SOLUTIONS USA INC	00001	979685	370930	8/11/2020	2,459.70

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	G4S SECURE SOLUTIONS USA INC	00001	979686	370930	8/11/2020	2,459.70
	G4S SECURE SOLUTIONS USA INC	00001	979688	370930	8/11/2020	2,459.70
	G4S SECURE SOLUTIONS USA INC	00001	979689	370930	8/11/2020	1,997.76
	G4S SECURE SOLUTIONS USA INC	00001	979691	370930	8/11/2020	2,429.70
	G4S SECURE SOLUTIONS USA INC	00001	979692	370930	8/11/2020	2,459.70
	G4S SECURE SOLUTIONS USA INC	00001	979693	370930	8/11/2020	2,459.70
	G4S SECURE SOLUTIONS USA INC	00001	979694	370930	8/11/2020	2,457.51
	GALLS LLC	00001	979869	371146	8/13/2020	678.04
	GALLS LLC	00001	979952	371146	8/13/2020	2,953.75
	GALLS LLC	00001	979953	371146	8/13/2020	782.45
	GALLS LLC	00001	979953	371146	8/13/2020	766.05
	GALLS LLC	00001	979954	371146	8/13/2020	1,481.25
	GALLS LLC	00001	979899	371146	8/13/2020	2,196.09
	GALLS LLC	00001	979900	371146	8/13/2020	1,609.50
	GALLS LLC	00001	979901	371146	8/13/2020	139.97
	GALLS LLC	00001	979902	371146	8/13/2020	39.95
	GALLS LLC	00001	979903	371146	8/13/2020	1,548.25
	GALLS LLC	00001	979904	371146	8/13/2020	135.75
	GALLS LLC	00001	979905	371146	8/13/2020	139.97
	GALLS LLC	00001	979906	371146	8/13/2020	1,548.50
	GALLS LLC	00001	979907	371146	8/13/2020	1,548.50
	GALLS LLC	00001	979908	371146	8/13/2020	1,548.50
	GALLS LLC	00001	979909	371146	8/13/2020	1,609.50
	GALLS LLC	00001	979910	371146	8/13/2020	612.50
	GALLS LLC	00001	979911	371146	8/13/2020	65.37
	GALLS LLC	00001	979912	371146	8/13/2020	193.82
	GALLS LLC	00001	979913	371146	8/13/2020	492.98
	GALLS LLC	00001	979914	371146	8/13/2020	582.54
	GALLS LLC	00001	979915	371146	8/13/2020	159.74
	GALLS LLC	00001	979916	371146	8/13/2020	83.95
	GALLS LLC	00001	979917	371146	8/13/2020	466.07
	GALLS LLC	00001	979918	371146	8/13/2020	341.38
	GALLS LLC	00001	979919	371146	8/13/2020	68.91
	GALLS LLC	00001	979920	371146	8/13/2020	139.97
	GALLS LLC	00001	979921	371146	8/13/2020	139.97
	GALLS LLC	00001	979922	371146	8/13/2020	71.06

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	979923	371146	8/13/2020	81.77
	GALLS LLC	00001	979924	371146	8/13/2020	120.00
	GALLS LLC	00001	979925	371146	8/13/2020	1,795.45
	GALLS LLC	00001	979926	371146	8/13/2020	120.90
	GALLS LLC	00001	979927	371146	8/13/2020	600.00
	GALLS LLC	00001	979928	371146	8/13/2020	1,367.46
	GALLS LLC	00001	979929	371146	8/13/2020	157.25
	GALLS LLC	00001	979930	371146	8/13/2020	132.89
	GALLS LLC	00001	979931	371146	8/13/2020	65.37
	GALLS LLC	00001	979932	371146	8/13/2020	2,363.83
	GALLS LLC	00001	979933	371146	8/13/2020	308.25
	GAM ENTERPRISES INC	00001	979940	371146	8/13/2020	269.55
	GAM ENTERPRISES INC	00001	979941	371146	8/13/2020	162.00
	GAM ENTERPRISES INC	00001	979942	371146	8/13/2020	175.50
	GAM ENTERPRISES INC	00001	979943	371146	8/13/2020	473.49
	GAM ENTERPRISES INC	00001	979944	371146	8/13/2020	2,213.30
	INSIGHT PUBLIC SECTOR	00001	979956	371146	8/13/2020	295.00
	INSIGHT PUBLIC SECTOR	00001	979956	371146	8/13/2020	7,063.39
	INTERVET INC	00001	979897	371146	8/13/2020	1,950.00
	KD SERVICE GROUP	00001	980005	371146	8/13/2020	254.50
	MCDONALD YONG HUI V	00001	979995	371146	8/13/2020	4,791.06
	MURPHY RICK	00001	979996	371146	8/13/2020	3,429.74
	MWI VETERINARY SUPPLY CO	00001	979893	371146	8/13/2020	15.64
	NCS PEARSON INC	00001	979984	371146	8/13/2020	66.50
	NORTHGLENN AMBULANCE	00001	979983	371146	8/13/2020	96.60
	OFFICESCAPES OF DENVER LLLP	00001	979961	371146	8/13/2020	18,734.55
	ORACLE AMERICA INC	00001	979881	371146	8/13/2020	2,062.94
	ORACLE AMERICA INC	00001	979882	371146	8/13/2020	4,808.59
	PEARL COUNSELING ASSOCIATES	00001	979998	371146	8/13/2020	350.00
	PEARL COUNSELING ASSOCIATES	00001	979999	371146	8/13/2020	6,027.00
	PITNEY BOWES GLOBAL FINANCIAL	00001	979992	371146	8/13/2020	1,239.21
	SAUNDERS CONSTRUCTION INC	00001	979711	370941	8/11/2020	15,630.46
	SAUNDERS CONSTRUCTION INC	00001	979712	370941	8/11/2020	303,466.85
	SUMMIT FOOD SERVICE LLC	00001	979990	371146	8/13/2020	19,573.42
	SUMMIT FOOD SERVICE LLC	00001	979991	371146	8/13/2020	20,461.14
	THERMAL & MOISTURE PROTECTION	00001	979877	371146	8/13/2020	450.00

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	TYGRETT DEBRA R	00001	979986	371146	8/13/2020	120.00
	VEIGA BRASIL III RICHARD A	00001	979963	371146	8/13/2020	2,730.00
	WHITESTONE CONSTRUCTION SERVIC	00001	979966	371146	8/13/2020	7,125.00
	WILBUR-ELLIS COMPANY LLC	00001	979949	371146	8/13/2020	3,505.00
	WRIGHTWAY INDUSTRIES INC	00001	979934	371146	8/13/2020	660.24
					Account Total	629,309.79
					Department Total	630,712.91

9252	GF- Admin/Org Support	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	IMPACT CHARITABLE	00001	979609	370733	8/7/2020	50,000.00
					Account Total	50,000.00
					Department Total	50,000.00

5	Golf Course Enterprise Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	AAA PEST PROS	00005	979884	371146	8/13/2020	45.00
					Account Total	45.00
	Vendor Fee Sales Tax - State					
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	1,642.64
					Account Total	1,642.64
					Department Total	1,687.64

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Contract Employment					
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	22,277.73
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	2,635.01
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	10,222.49
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	1,258.11
					Account Total	36,393.34
	Equipment Rental					
	BUCKEYE WELDING SUPPLY CO INC	00005	979628	370754	8/7/2020	30.60
					Account Total	30.60
	Fuel, Gas & Oil					
	AGFINITY INC	00005	979625	370754	8/7/2020	1,788.79
	AGFINITY INC	00005	979626	370754	8/7/2020	2,438.30
					Account Total	4,227.09
	Gas & Electricity					
	XCEL ENERGY	00005	979635	370754	8/7/2020	44.73
	XCEL ENERGY	00005	979636	370754	8/7/2020	47.35
					Account Total	92.08
	Grounds Maintenance					
	L L JOHNSON DIST	00005	979629	370754	8/7/2020	1,375.02
					Account Total	1,375.02
	Membership Dues					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	103.02
					Account Total	103.02
	Repair & Maint Supplies					
	ALSCO AMERICAN INDUSTRIAL	00005	979627	370754	8/7/2020	54.36
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	119.47
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	871.90
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	178.43
					Account Total	1,224.16
	Vehicle Parts & Supplies					
	L L JOHNSON DIST	00005	979630	370754	8/7/2020	61.13
	L L JOHNSON DIST	00005	979631	370754	8/7/2020	783.61
	MASEK GOLF CARS OF COLORADO	00005	979632	370754	8/7/2020	139.71

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	POTESTIO BROTHER EQUIPMENT	00005	979634	370754	8/7/2020	741.00
					Account Total	1,725.45
					Department Total	45,170.76

5021	Golf Course- Pro Shop	Fund	Voucher	Batch No	GL Date	Amount
	Contract Employment					
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	23,607.88
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	2,884.19
					Account Total	26,492.07
	Equipment Rental					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	273.00
					Account Total	273.00
	Gas & Electricity					
	XCEL ENERGY	00005	979636	370754	8/7/2020	244.10
					Account Total	244.10
	Golf Carts					
	MASEK GOLF CARS OF COLORADO	00005	979633	370754	8/7/2020	223.69
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	32.37
					Account Total	256.06
	Golf Merchandise					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	10.00
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	292.00
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	1,008.74
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	168.72
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	5,026.37
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	1,669.60
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	482.60
					Account Total	8,658.03
	Golf Range Expense					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	2,625.00
					Account Total	2,625.00
	Janitorial Services					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	1,104.45
					Account Total	1,104.45
	Operating Supplies					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	15.08
					Account Total	15.08
	Other Professional Serv					

5021	Golf Course- Pro Shop	Fund	Voucher	Batch No	GL Date	Amount
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	346.29
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	346.29
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	326.27-
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	229.54
					Account Total	595.85
	Other Repair & Maint					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	4,850.00
					Account Total	4,850.00
	Postage & Freight					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	22.60
					Account Total	22.60
	Repair & Maint Supplies					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	31.08
					Account Total	31.08
	Security Service					
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	647.50
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	1,295.00
					Account Total	1,942.50
	Telephone					
	PROFESSIONAL RECREATION MGMT I	00005	979787	371041	8/12/2020	582.07
					Account Total	582.07
	Water/Sewer/Sanitation					
	PROFESSIONAL RECREATION MGMT I	00005	979985	371150	8/13/2020	614.73
					Account Total	614.73
					Department Total	48,306.62

31	Head Start Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	CESCO LINGUISTIC SERVICE INC	00031	979887	371146	8/13/2020	60.00
	CESCO LINGUISTIC SERVICE INC	00031	979888	371146	8/13/2020	60.00
	CHILDRENS HOSPITAL	00031	979894	371146	8/13/2020	825.00
					Account Total	945.00
					Department Total	945.00

935120	HHS Grant	Fund	Voucher	Batch No	GL Date	Amount
	Building Rental					
	COMMUNITY REACH CENTER FOUNDAT	00031	979666	370842	8/10/2020	6,515.84
					Account Total	6,515.84
	Operating Supplies					
	CINTAS CORPORATION NO 2	00031	979664	370842	8/10/2020	160.89
	L & N SUPPLY COMPANY INC	00031	979667	370842	8/10/2020	1,038.00
					Account Total	1,198.89
	Other Professional Serv					
	COLO DEPT OF HUMAN SERVICES	00031	979665	370842	8/10/2020	70.00
	IDEMIA IDENTITY & SECURITY USA	00031	979668	370842	8/10/2020	49.50
	IDEMIA IDENTITY & SECURITY USA	00031	979669	370842	8/10/2020	49.50
					Account Total	169.00
	Telephone					
	CENTURY LINK	00031	979661	370842	8/10/2020	142.31
	CENTURY LINK	00031	979662	370842	8/10/2020	404.41
	CENTURY LINK	00031	979663	370842	8/10/2020	149.93
					Account Total	696.65
					Department Total	8,580.38

19	Insurance Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	FIT SOLDIERS LLC	00019	979946	371146	8/13/2020	300.00
					Account Total	300.00
					Department Total	300.00

6107	Open Space Projects	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	XCEL ENERGY	00027	979614	370743	8/7/2020	12.89
					Account Total	12.89
					Department Total	12.89

27	Open Space Projects Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	STREAM LANDSCAPE ARCHITECTURE	00027	979892	371146	8/13/2020	555.00
	STREAM LANDSCAPE ARCHITECTURE	00027	979878	371146	8/13/2020	3,269.76
					Account Total	3,824.76
					Department Total	3,824.76

6202	Open Space Tax- Grants	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	EAGLE CREEK METROPOLITAN DISTR	00028	978812	369777	7/28/2020	69,540.48
					Account Total	69,540.48
					Department Total	69,540.48

1015	People Services	Fund	Voucher	Batch No	GL Date	Amount
	Tuition Reimbursement					
	GAUGLER MARISSA	00001	979702	370933	8/11/2020	2,500.00
	LIMA PEDRO F	00001	979678	370921	8/11/2020	1,175.24
	STOGSDILL SHANNA	00001	979679	370921	8/11/2020	1,039.50
					Account Total	4,714.74
					Department Total	4,714.74

5010	PKS- Fair	Fund	Voucher	Batch No	GL Date	Amount
	Fair Expenses-General					
	BALDWIN MARY	00001	979727	370950	8/11/2020	150.00
	CHRISTIAN VICKI	00001	979728	370950	8/11/2020	150.00
	COLOR CORRAL	00001	979733	370952	8/11/2020	2,370.10
	FEY TOM E	00001	979726	370950	8/11/2020	150.00
	LOWRY SAM	00001	979734	370952	8/11/2020	150.00
					Account Total	2,970.10
					Department Total	2,970.10

5012	PKS- Regional Complex	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	XCEL ENERGY	00001	979613	370743	8/7/2020	16.04
					Account Total	16.04
					Department Total	16.04

5016	PKS- Trail Ranger Patrol	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	XCEL ENERGY	00001	979612	370743	8/7/2020	406.87
					Account Total	406.87
	Water/Sewer/Sanitation					
	NORTH PECOS WATER & SANITATION	00001	979611	370743	8/7/2020	41.13
					Account Total	41.13
					Department Total	448.00

1089	PLN- Boards & Commissions	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	GRONQUIST CHRIS	00001	979607	370645	8/6/2020	65.00
	HAGGERTY BRIAN	00001	979605	370645	8/6/2020	65.00
	MCCREARY RAPHAEL	00001	979602	370645	8/6/2020	65.00
	TONSAGER DENNIS	00001	979606	370645	8/6/2020	65.00
	TRELOAR TARA A	00001	979604	370645	8/6/2020	65.00
	WOLFE SANDRA KAY	00001	979603	370645	8/6/2020	65.00
					Account Total	390.00
					Department Total	390.00

3056	PW - Capital Improvement Plan	Fund	Voucher	Batch No	GL Date	Amount
	Land					
	CLASSIC II HOLDINGS LLC	00013	979610	370737	8/6/2020	2,500.00
					Account Total	2,500.00
	Road & Streets					
	GUERRERO SIMON	00013	979371	370289	8/6/2020	1,800.00
	UNITED POWER	00013	979650	370836	8/10/2020	300.00
					Account Total	2,100.00
					Department Total	4,600.00

3031	PW - Operations & Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Debris Removal					
	METECH RECYCLING	00013	979800	371044	8/12/2020	504.05
	THE GOODYEAR TIRE AND RUBBER C	00013	979799	371044	8/12/2020	1,224.00
					Account Total	1,728.05
	Gas & Electricity					
	UNITED POWER (UNION REA)	00013	979830	371059	8/12/2020	23.16
	UNITED POWER (UNION REA)	00013	979831	371059	8/12/2020	33.00
	UNITED POWER (UNION REA)	00013	979832	371059	8/12/2020	16.50
	UNITED POWER (UNION REA)	00013	979833	371059	8/12/2020	34.00
	UNITED POWER (UNION REA)	00013	979834	371059	8/12/2020	88.49
	UNITED POWER (UNION REA)	00013	979835	371059	8/12/2020	36.00
	UNITED POWER (UNION REA)	00013	979836	371059	8/12/2020	16.50
	UNITED POWER (UNION REA)	00013	979837	371059	8/12/2020	16.50
	UNITED POWER (UNION REA)	00013	979838	371059	8/12/2020	33.00
	UNITED POWER (UNION REA)	00013	979839	371059	8/12/2020	48.28
	UNITED POWER (UNION REA)	00013	979840	371059	8/12/2020	20.00
	UNITED POWER (UNION REA)	00013	979841	371059	8/12/2020	153.79
	UNITED POWER (UNION REA)	00013	979842	371059	8/12/2020	118.52
	UNITED POWER (UNION REA)	00013	979843	371059	8/12/2020	131.40
	UNITED POWER (UNION REA)	00013	979844	371059	8/12/2020	41.05
	UNITED POWER (UNION REA)	00013	979845	371059	8/12/2020	99.26
	UNITED POWER (UNION REA)	00013	979846	371059	8/12/2020	48.28
	UNITED POWER (UNION REA)	00013	979847	371059	8/12/2020	44.78
	XCEL ENERGY	00013	979820	371059	8/12/2020	79.72
	XCEL ENERGY	00013	979821	371059	8/12/2020	74.68
	XCEL ENERGY	00013	979822	371059	8/12/2020	60.24
	XCEL ENERGY	00013	979823	371059	8/12/2020	222.58
	XCEL ENERGY	00013	979824	371059	8/12/2020	93.54
	XCEL ENERGY	00013	979825	371059	8/12/2020	22,595.26
	XCEL ENERGY	00013	979826	371059	8/12/2020	4,573.01
	XCEL ENERGY	00013	979827	371059	8/12/2020	111.07
	XCEL ENERGY	00013	979828	371059	8/12/2020	51.20
	XCEL ENERGY	00013	979829	371059	8/12/2020	74.75
					Account Total	28,938.56
	Maintenance Contracts					

3031	PW - Operations & Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	DAVEY TREE EXPERT CO	00013	979818	371044	8/12/2020	2,700.00
					Account Total	2,700.00
	Operating Supplies					
	ALSCO AMERICAN INDUSTRIAL	00013	979790	371044	8/12/2020	88.40
	ALSCO AMERICAN INDUSTRIAL	00013	979791	371044	8/12/2020	102.77
	CINTAS FIRST AID & SAFETY	00013	979792	371044	8/12/2020	84.41
	CINTAS FIRST AID & SAFETY	00013	979793	371044	8/12/2020	138.72
					Account Total	414.30
	Road Oil					
	COBITCO INC	00013	979795	371044	8/12/2020	125.84
	COBITCO INC	00013	979796	371044	8/12/2020	181.50
	COBITCO INC	00013	979797	371044	8/12/2020	273.46
	COBITCO INC	00013	979798	371044	8/12/2020	239.58
					Account Total	820.38
	Traffic Signal Maintenance					
	UTILITY NOTIFICATION CENTER OF	00013	979803	371044	8/12/2020	154.96
					Account Total	154.96
	Water/Sewer/Sanitation					
	PREMIER PORTABLES	00013	979801	371044	8/12/2020	350.00
	SOUTH ADAMS WATER & SANITATION	00013	979802	371044	8/12/2020	247.77
					Account Total	597.77
					Department Total	35,354.02

13	Road & Bridge Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	EP&A ENVIROTAC INC	00013	979951	371146	8/13/2020	35,644.18
	EST INC	00013	979880	371146	8/13/2020	32,182.42
	GROUND ENGINEERING CONSULTANTS	00013	979872	371146	8/13/2020	1,243.00
	JALISCO INTL INC	00013	979968	371146	8/13/2020	198,776.86
	ORIUX	00013	979962	371146	8/13/2020	2,971.73
	W L CONTRACTORS INC	00013	979886	371146	8/13/2020	6,697.42
					Account Total	277,515.61
	Retainages Payable					
	JALISCO INTL INC	00013	979968	371146	8/13/2020	9,938.84-
					Account Total	9,938.84-
					Department Total	267,576.77

2092	Sheriff Flatrock	Fund	Voucher	Batch No	GL Date	Amount
	Merchandise					
	STATE OF COLORADO	00050	979849	371062	8/12/2020	.08-
					Account Total	.08-
					Department Total	.08-

2015	SHF- Civil Section	Fund	Voucher	Batch No	GL Date	Amount
	Sheriff's Fees					
	CASTLE AND CASTLE	00001	979642	370834	8/10/2020	2.50
	FORT COLLINS POLICE SERVICES	00001	979643	370834	8/10/2020	56.00
	GALDEAN ALEJANDRO	00001	979648	370834	8/10/2020	19.00
	HALLIDAY WATKINS AND MANN	00001	979641	370834	8/10/2020	143.00
	LOYA OLIVIA	00001	979649	370834	8/10/2020	19.00
	ODEGARD CHERYL ANN	00001	979645	370834	8/10/2020	19.00
	SALAZAR MA TRINIDAD	00001	979644	370834	8/10/2020	66.00
	WOODARD MATTHEW	00001	979647	370834	8/10/2020	19.00
					Account Total	343.50
					Department Total	343.50

2016	SHF- Detective Division	Fund	Voucher	Batch No	GL Date	Amount
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	979806	371048	8/12/2020	134.48
					Account Total	134.48
	Machinery					
	SAFEWARE INC	00001	979808	371048	8/12/2020	6,423.37
					Account Total	6,423.37
	Medical Services					
	DENVER HEALTH & HOSPITAL AUTHO	00001	979805	371048	8/12/2020	680.00
	NORTH COLORADO MEDICAL CTR	00001	979807	371048	8/12/2020	621.00
					Account Total	1,301.00
	Other Communications					
	CENTURY LINK	00001	979804	371048	8/12/2020	85.00
					Account Total	85.00
					Department Total	7,943.85

2071	SHF- Detention Facility	Fund	Voucher	Batch No	GL Date	Amount
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	979806	371048	8/12/2020	906.92
					Account Total	906.92
	Operating Supplies					
	SUMMIT FOOD SERVICE LLC	00001	979809	371048	8/12/2020	1,287.52
	SUMMIT FOOD SERVICE LLC	00001	979810	371048	8/12/2020	1,224.28
					Account Total	2,511.80
					Department Total	3,418.72

2010	SHF- MIS Unit	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	KENNY ELECTRIC SERVICE INC	00001	979819	371057	8/12/2020	216.00
					Account Total	216.00
					Department Total	216.00

2017	SHF- Patrol Division	Fund	Voucher	Batch No	GL Date	Amount
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	979806	371048	8/12/2020	136.12
					Account Total	136.12
					Department Total	136.12

2018	SHF- Records/Warrants Section	Fund	Voucher	Batch No	GL Date	Amount
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	979806	371048	8/12/2020	22.96
					Account Total	22.96
					Department Total	22.96

9295	Solid Waste Operations	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	COLO DEPT OF PUBLIC HEALTH & E	00025	979599	370597	8/6/2020	250.00
					Account Total	250.00
					Department Total	250.00

25	Waste Management Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	IRON WOMAN CONSTRUCTION	00025	979889	371146	8/13/2020	187,196.75
	IRON WOMAN CONSTRUCTION	00025	979891	371146	8/13/2020	295,076.95
	IRON WOMAN CONSTRUCTION	00025	979890	371146	8/13/2020	368,179.05
					Account Total	850,452.75
	Retainages Payable					
	IRON WOMAN CONSTRUCTION	00025	979891	371146	8/13/2020	14,753.85-
	IRON WOMAN CONSTRUCTION	00025	979890	371146	8/13/2020	18,408.95-
	IRON WOMAN CONSTRUCTION	00025	979889	371146	8/13/2020	9,359.84-
					Account Total	42,522.64-
					Department Total	807,930.11

97500	WIOA YOUTH OLDER	Fund	Voucher	Batch No	GL Date	Amount
	Clnt Trng-Work Experience					
	LAJARAZO JAMIE	00035	979439	370488	8/5/2020	150.00
	MUNOZ PARRA ANA P	00035	979440	370488	8/5/2020	215.00
	PORTILLO YOCELYN	00035	979441	370488	8/5/2020	150.00
					Account Total	515.00
					Department Total	515.00

Grand Total	**4,399,743.69**

Board of County Commissioners
Minutes of Commissioners' Proceedings

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

Tuesday
August 18, 2020
9:30 AM

1. **ROLL CALL**

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

2. **PLEDGE OF ALLEGIANCE**

3. **MOTION TO APPROVE AGENDA**

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

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

4. **AWARDS AND PRESENTATIONS**

   A. Proclamation of August 2020 as Child Support Awareness Month

5. **PUBLIC COMMENT**

   A. Citizen Communication

   B. Elected Officials' Communication

6. **CONSENT CALENDAR**

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

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

A. List of Expenditures Under the Dates of August 3-7,2020

B. Minutes of the Commissioners' Proceedings from August 11, 2020

C. Resolution Regarding Defense and Indemnification of Joseph Archuleta, Darius Ardrey, Yvon Benoit, and Richard Reigenborn as Defendants Pursuant to C.R.S. § 24-10-101, Et Seq.
(File approved by ELT)

D. Revised Resolution Establishing Office Closures for 2020
(File approved by ELT)

E. Resolution Approving Agreement Regarding Funding of Major Drainageway Planning and Flood Hazard Delineation for Upper Crooked Run and Tributaries Agreement No. 20-01.34
(File approved by ELT)

F. Resolution Approving Agreement Regarding Funding of Major Drainageway Planning for Ragweed Drain and Tributaries Agreement No. 20-06.10
(File approved by ELT)

G. Resolution Granting Easements between United Power and Adams County for Brandt and Ergers Sites
(File approved by ELT)

H. Resolution Approving Agreement Regarding Funding of Major Drainageway Planning and Flood Hazard Area Delineation for Second Creek Tributaries Agreement No. 20-03.26
(File approved by ELT)

I. Resolution Approving Memorandum of Understanding Regarding Community Corrections First Distribution Facility Payment Plan by and between Adams County, Colorado and CoreCivic, Inc.
(File approved by ELT)

J. Resolution Approving Right-of-Way Agreement between Adams County and Shanghai Land Investment, LLC for Property Necessary for the Traffic Signal Cabinet Upgrade Project
(File approved by ELT)

K. Resolution Adopting Hearing Officer's Recommendations for Decision Regarding Property Tax Abatement Petitions
(File approved by ELT)

L. Resolution Approving Right-of-Way Agreement between Adams County and Spera Family Investment Co., for Property Necessary for the East 58th Avenue Improvements Project – East 58th Avenue from Clarkson Street to York Street
(File approved by ELT)

M. Resolution Approving Right-of-Way Agreement between Adams County and Patricia R. Gibbons and The Estate of Michael F. Spera for Property Necessary for the East 58th Avenue Improvements Project – East 58th Avenue from Clarkson Street to York Street
(File approved by ELT)

N. Resolution Approving Right-of-Way Agreement between Adams County and Zakya Ahadi for Property Necessary for the East 58th Avenue Improvements Project – East 58th Avenue from Clarkson Street to York Street
(File approved by ELT)

O. A Resolution Authorizing a Lease Purchase Transaction for the Purposes of Refunding Certain Outstanding Obligations of the County and in Connection Therewith, Authorizing the Execution and Deliver of a Site Lease between Adams County as Lessor and a Financial Institution to be Determined as Lessee a Lease Purchase Agreement between the County, as Lessee, and Such Financial Institution as Lessor and Other Related Documents; Authorizing Officials of the County to Take All Action Necessary to Carry Out the Transactions Contemplated Hereby; and Providing for Related Matters
(File approved by ELT)

7. NEW BUSINESS

A. COUNTY MANAGER

1. Resolution Approving an Agreement between Adams County and IDEA Forum Inc., to Provide Substance Abuse Monitoring Services for the Adams County Human Services Department
(File approved by ELT)
A motion was made by Commissioner O'Dorisio, seconded by Commissioner Hodge, that this New Business be approved. The motion carried by the following vote:

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

2. Resolution Approving an Agreement between Adams County and Recovery Monitoring Solutions to Provide Substance Abuse Monitoring Services for the Adams County Human Services Department
(File approved by ELT)
A motion was made by Commissioner O'Dorisio, seconded by Commissioner Hodge, that this New Business be approved. The motion carried by the following vote:

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

3. Resolution Approving an Agreement between Adams County and Mark Young Construction, LLC, for the Mezzanine Build at the Government Center
(File approved by ELT)
A motion was made by Commissioner Henry, seconded by Commissioner O'Dorisio, that this New Business be approved. The motion carried by the following vote:

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

4. Resolution Approving an Agreement between Adams County and Douglass Colony Group for the Justice Center Roof Replacement
(File approved by ELT)
A motion was made by Commissioner Tedesco, seconded by Commissioner O'Dorisio, that this New Business be approved. The motion carried by the following vote:

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

B. COUNTY ATTORNEY

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

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

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

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

10. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Request for a Major Subdivision Final Plat for Ridgeview Estates, Filing No. 1
FROM: Jill Jennings Golich, Director
AGENCY/DEPARTMENT: Community and Economic Development Department
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves PLT2019-00026; Ridgeview Estates, Filing No. 1 with the recommended Findings-of Facts, Conditions, and Notes

BACKGROUND:

On August 13, 2019, the Board of County Commissioners approved a major subdivision preliminary plat for Ridgeview Estates to create 21 lots on approximately 62.3 acres. The subject application is for Filing, No. 1 and consists of 11 of the 21 lots.

David Moore, on behalf of Alliance Development Services, is requesting a major subdivision final plat for the Ridgeview Estates Subdivision, Filing No. 1. The final plat for Filing No. 1 consists of 11 single-family residential lots, two non-residential tracts, and associated public streets.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community and Economic Development
County Attorney

ATTACHED DOCUMENTS:

Resolution Approving Application in Case #PLT2019-00026
Board of County Commissioners Packet

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION APPROVING APPLICATION IN CASE # PLT2019-00026; RIDGEVIEW ESTATES FINAL PLAT, FILING NO. 1

WHEREAS, this case involves a request for a Major Subdivision Final Plat to create eleven single-family residential lots, two non-residential tracts, and associated streets.

APPROXIMATE LOCATION: Directly to the south of 28300 E 160th Avenue

LEGAL DESCRIPTION:
KNOW ALL MEN BY THESE PRESENTS, THAT RIDGEVIEW ESTATE LLC, A COLORADO CORPORATION, BEING THE OWNER OF A PORTION OF THE WEST HALF OF SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:
BEGINNING AT THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., THENCE S 00°05'13" E ALONG THE EAST LINE OF THE WEST HALF OF SECTION 10, WITH ALL BEARINGS CONTAINED HEREON RELATIVE THERETO, A DISTANCE OF 1495.68 FEET;
THENCE DEPARTING SAID EAST LINE OF THE WEST HALF OF SECTION 10, N 76°50'50" W, A DISTANCE OF 903.48 FEET;
THENCE N 69°27'56" W A DISTANCE OF 596.98 FEET;
THENCE N 60°05'53" W A DISTANCE OF 537.87 FEET;
THENCE N 39°37'58" W A DISTANCE OF 507.03 FEET;
THENCE N 17°26'04" W A DISTANCE OF 38.65 FEET;
THENCE N 90°00'00" W A DISTANCE OF 406.46 FEET, TO A POINT ON THE EAST LINE OF THE NORTHEAST QUARTER OF SECTION 9;
THENCE ALONG SAID EAST LINE OF THE NORTHEAST QUARTER OF SAID SECTION 9, N 00°07'50" W A DISTANCE OF 373.61 FEET, TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND DESCRIBED IN BOOK 4431 PAGE 18, COUNTY PUBLIC RECORDS;
THENCE ALONG THE SOUTH LINE OF SAID PARCEL, THE FOLLOWING TWO (2) COURSES:
1) S 89°23'03" E PARALLEL WITH AND 40.00 FEET SOUTH OF, BY PERPENDICULAR MEASUREMENT, THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10, A DISTANCE OF 257.32 FEET;
2) THENCE N 72°13'56" E A DISTANCE OF 126.83 FEET, TO A POINT ON THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10;
THENCE ALONG SAID NORTH LINE OF THE WEST HALF OF SECTION 10, S 89°23'03" E, A DISTANCE OF 2267.15 FEET TO THE POINT OF BEGINNING;
CONTAINING AN AREA OF 2,713,709 SQUARE FEET OF 62.298 ACRES MORE OR LESS.

WHEREAS, the Board of County Commissioners held a public hearing on the application on the 1st day of September, 2020; and

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that based upon the evidence presented at the hearing, the application in this case is hereby APPROVED based upon the following findings-of-fact and subject to the fulfillment of the following conditions by the applicant:

RECOMMENDED FINDINGS-OF-FACT

1. The final plat is consistent and conforms to the approved preliminary plat.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Recommended Condition:

1. All utilities shall be located underground pursuant to the Adams County Development Standards and Regulations.

Recommended Note to the Applicant:

1. The applicant shall comply with all building, zoning, fire, engineering, and health codes and regulations during the development of the subject site.
2. The Colorado Division of Parks and Wildlife has requested that a survey of the property for nesting of burrowing owls occurs if earthmoving occurs between March 15th and October 31st of any given year. These raptors are classified as a state threatened species and are protected by both state and federal laws, including the Migratory Bird Treaty Act. These laws prohibit the killing of burrowing owls or disturbance of their nests. Guidelines for performing a burrowing owl survey can also be obtained from the local District Wildlife Manager.
3. The Colorado Division of Parks and Wildlife recommends that the HOA inform future residents that wildlife such as fox, coyotes, beavers, and raccoons might frequent the development area in search of food and cover. Residents moving into this area should take the proper precautions to prevent unnecessary conflicts between people and pets with wildlife.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

CASE NO.: PLT2019-00026
CASE NAME: RIDGEVIEW ESTATES, FILING NO. 1

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COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

Board of County Commissioners September 1, 2020

CASE No.: **PLT2019-00026**	CASE NAME: **Ridgeview Estates, Filing No. 1**

Owner's Name:	Ridgeview Estates, LLC
Applicant's Name:	David Moore, Alliance Development Services
Applicant's Address:	16415 W 85th Ln, Unit B, Arvada, Colorado 80007
Location of Requests:	Directly to the south of 28300 East 160th Avenue
Nature of Requests:	1) Major Subdivision Final Plat to create 11 single-family residential lots and 2 non-residential tracts; 2) Subdivision Improvements Agreement (SIA)
Zone District:	Residential Estate (RE)
Site Size:	36.28 acres
Proposed Uses:	Single-Family Residential
Existing Use:	Vacant
Hearing Date(s):	**BoCC: September 1st, 2020 / 9:30 a.m.**
Report Date:	August 5, 2020
Case Manager:	Layla Bajelan
Staff Recommendation:	APPROVAL of the Final Plat and Subdivision Improvements Agreement with 7 Findings-of-Fact, 1 Condition, and 3 Notes

SUMMARY OF PREVIOUS APPLICATIONS

On August 13, 2019, the Board of County Commissioners approved a major subdivision preliminary plat for Ridgeview Estates to create 21 lots on approximately 62.3 acres. The subject application is for Filing, No. 1 and consists of 11 of the 21 lots.

SUMMARY OF APPLICATION

Background:

David Moore, on behalf of Alliance Development Services, is requesting a major subdivision final plat for the Ridgeview Estates Subdivision, Filing No. 1. The final plat for Filing No. 1 consists of 11 single-family residential lots, two non-residential tracts, and associated public streets.

Site Characteristics:

The subject site is located approximately one-half mile southwest of the intersection of Hayesmount Road and East 162nd Avenue and is currently undeveloped. East 160th Avenue abuts the northwest portion of the site and provides direct access to the development through a newly proposed section of Monaghan Road, which will serve as the main entrance for the proposed subdivision. The Adams County Development Review Engineers and Brighton Fire Department have confirmed that the subdivision will show compliance with the minimum fire requirements, as Monaghan Rd. will not be fully built out until Filing No. 2.

Development Standards and Regulations Requirements

Major Subdivision (Final Plat):

Per Section 2-02-19-04 of the County's Development Standards and Regulations, a final plat must be consistent and conform to an approved preliminary plat. On August 13, 2019, the Board of County Commissioners approved a preliminary plat on the subject property. The subject request conforms to the corresponding section of the approved preliminary plat.

The proposed plat conforms to the criteria for approval for a major subdivision final plat as outlined in Section 2-02-19-04-05 of the County's Development Standards. These standards include conformance to the County's Comprehensive Plan, the subdivision design standards, evidence of adequate water and sewer supply, adequate drainage improvements, adequate public infrastructure, and compatibility with the surrounding area. Per Section 5-03-03 of the County's Development Standards and Regulations, subdivision plats and lot dimensions are required to conform to requirements of the zone district in which the property is located. In addition, all lots created by a subdivision shall have access to a County-maintained right-of-way. The property is located within the Residential Estate (RE) zone district, which has a minimum one-acre lot size and a minimum lot width requirement of 100-feet for lots served by public water or sewer. The proposed subdivision lots will be served by the Greatrock North Water & Sanitation District and all lots conform to the minimum dimensional requirements for the RE zone district. In addition, all the proposed lots will have access to a public right-of-way.

The applicant has also provided evidence of adequate water and sewer to service the property. The application documents included a letter from the Greatrock North Water & Sanitation District stating that adequate water supply is available to support the proposed development. The Colorado Division of Water Resources reviewed the project and confirmed the availability of adequate water supply to support the development. Tri-County Health Department also reviewed the subject request and had no objection to the proposed subdivision utilizing onsite wastewater treatment systems (OWTS), provided that the OWTS is permitted, installed, and operated in compliance with regulation.

Subdivision Improvements Agreement (SIA):
Per Section 5-02-04 of the County's Development Standards and Regulations, a subdivision improvements agreement (SIA) is required with a final plat. The SIA allows for construction of infrastructure, such as public streets and storm sewers, to be constructed on the property. All streets in the development are proposed to be public and constructed to local street standards.

Future Land Use Designation:
The Adams County Comprehensive Plan designates the subject site as Agriculture; and this future land use designation is intended for large landholdings of 35 acres or more with very low density residential. Overall, the subject request would create approximately one dwelling unit per two and a half acres. The Residential Estate zone district allows for lots of less than 35 acres, and the request is consistent with the underlying zoning. The request is mostly consistent with the goals of the Comprehensive Plan to provide lower density housing in this area. Additionally, areas surrounding the subject site are also designated as Estate Residential future land use in the Comprehensive Plan. The creation of the subdivision will advance the County's long-term goal for providing estate residential areas, supporting the need for housing within the County.

This request would also be supported by the Comprehensive Plan, as Policy 11.1 *Permit Estate Residential Development in targeted locations* aims to allow Estate Residential development only where a similar land use pattern is already established or where such patterns may be appropriately extended. Policy 11.1.a. *Established Areas* allows for Estate Residential development as an appropriate land use only in areas established for such development in area designated on the Future Land Use map.

Surrounding Zoning Designations and Existing Use Activity:

Northwest A-3 Single-Family Residential	**North** A-1 Single-Family Residential	**Northeast** A-1 Single-Family Residential
West A-3 Single-Family Residential	**Subject Property** RE Vacant	**East** A-1 Single-Family Residential
Southwest A-3 Single-Family Residential	**South** A-3 Single-Family Residential	**Southeast** A-1 Single-Family Residential

Compatibility with the Surrounding Land Uses:
Properties to the north and east of the proposed subdivision are developed as single-family residential within approved subdivisions. These properties are developed at densities similar to the proposed Ridgeview Estates subdivision. The properties to the south and west consist of large parcels used for residential and agricultural purposes. The request for 11 single-family Residential Estate lots is compatible with existing development in the surrounding area and the County's future land use designation of Agriculture.

Staff Recommendations:

Based upon the application, the criteria for approval of a final plat, and recent site visit, staff recommends approval of this request with 7 findings-of-fact, 1 condition, and 3 notes.

RECOMMENDED FINDINGS-OF-FACT

1. The final plat is consistent and conforms to the approved preliminary plat.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Recommended Condition:

1. All utilities shall be located underground pursuant to the Adams County Development Standards and Regulations.

Recommended Note to the Applicant:

1. The applicant shall comply with all building, zoning, fire, engineering, and health codes and regulations during the development of the subject site.
2. The Colorado Division of Parks and Wildlife has requested that a survey of the property for nesting of burrowing owls occurs if earthmoving occurs between March 15th and October 31st of any given year. These raptors are classified as a state threatened species and are protected by both state and federal laws, including the Migratory Bird Treaty Act. These laws prohibit the killing of burrowing owls or disturbance of their nests. Guidelines for performing a burrowing owl survey can also be obtained from the local District Wildlife Manager.
3. The Colorado Division of Parks and Wildlife recommends that the HOA inform future residents that wildlife such as fox, coyotes, beavers, and raccoons might frequent the development area in search of food and cover. Residents moving into this area should take the proper precautions to prevent unnecessary conflicts between people and pets with wildlife.

COUNTY AGENCY COMMENTS

Adams County staff reviewed the subject request and determined the proposed final plat complies with the subdivision design standards outlined in Section 5-03 of the Development Standards and Regulations. All lot configurations proposed conform to lot dimensions in the RE zone district. Evidence of the ability to provide adequate water and individual septic facilities has been provided.

REFERRAL AGENCY COMMENTS

The Colorado Division of Parks and Wildlife (CPW) has requested that a survey of the property for nesting of burrowing owls occurs if earthmoving occurs between March 15th and October 31st of any given year. These raptors are classified as a state threatened species and are protected by both state and federal laws, including the Migratory Bird Treaty Act. These laws prohibit the killing of burrowing owls or disturbance of their nests. Guidelines for performing a burrowing owl survey can also be obtained from the local District Wildlife Manager.

In addition, Future residents should be informed that wildlife such as fox, coyotes, and raccoons might frequent the development area in search of food and cover. Coyotes, foxes, cottontail rabbits, and raccoons are several species that have adapted to living in urban environments. CPW recommends that people moving into and residing in this area take the proper precautions to prevent unnecessary conflicts with wildlife. Due to the potential for human-wildlife conflicts associated with this project, CPW has urged the applicant to consider educating future homeowners about the existence of wildlife in the area. Examples of these practices include keeping pet foods and bowls indoors, securing of garbage containers, a reminder that feeding of wildlife, except for birds, is illegal, and a reminder that pamphlets are available through CPW offices and online.

Greatrock North Water & Sanitation District has expressed some concerns regarding the enforcement of plat conditions i.e. Notes in the event a Homeowner's Association dissolves. The County does not regulate Homeowner's Associations, therefore if the Association dissolves, the responsibilities revert to the individual homeowners. The County has informed Greatrock, that a process change in how we review Final Plats would be required to effectively address their concerns. This process could take months, as it would require Stakeholder outreach and internal conversations with Staff and the Board of County Commissioners.

Responding with Concerns:

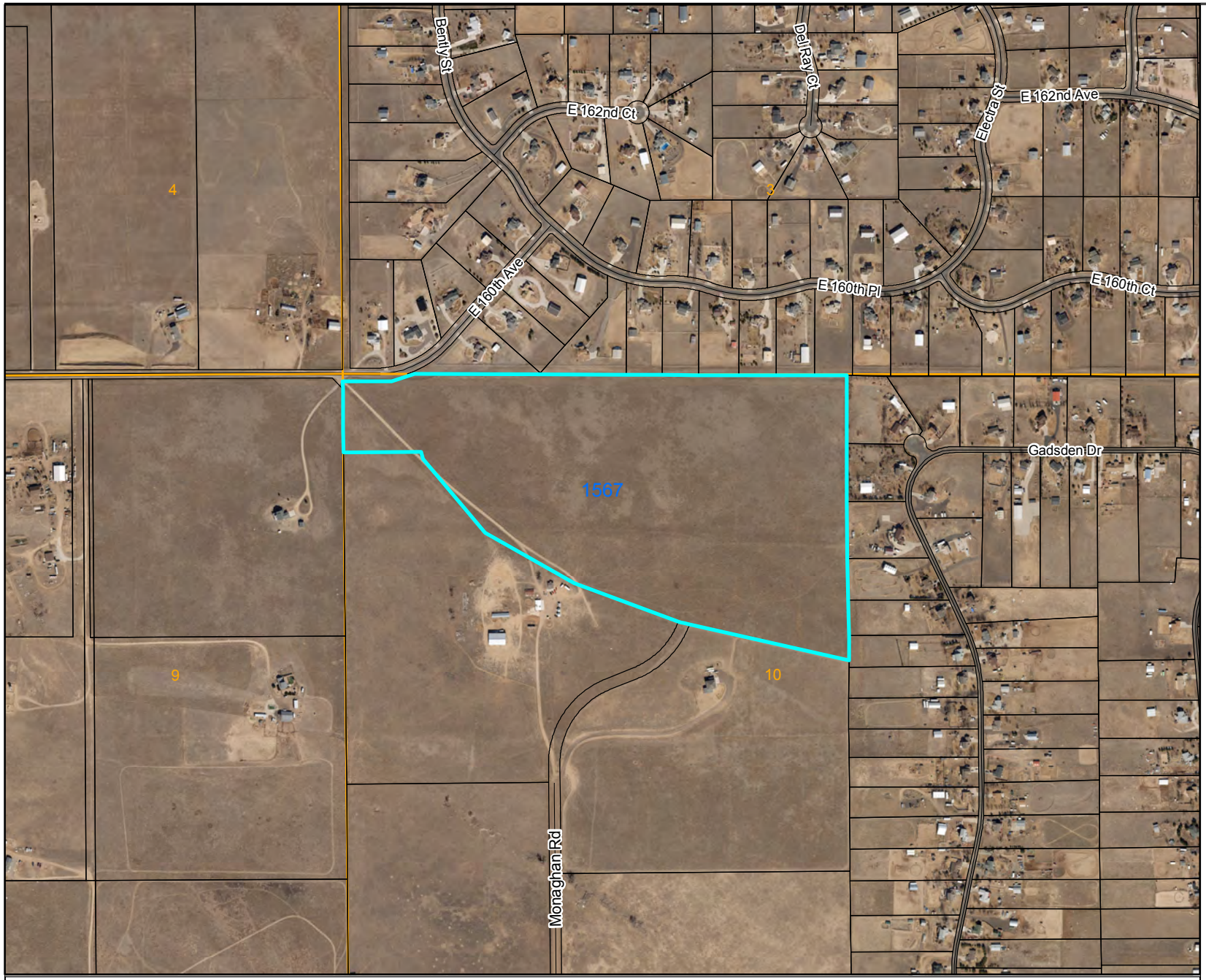
Colorado Division of Parks & Wildlife
Greatrock North Water & Sanitation District

Responding without Concerns:

Brighton Fire District
Colorado Division of Water Resources
Colorado Geological Survey
Tri-County Health Department
United Power
Xcel Energy

Notified but not Responding / Considered a Favorable Response:

Brighton School District 27J
Century Link
Comcast
Great Rock North HOA
Regional Transportation District
United Power
U.S. Postal Service
West Adams Soil Conservation District



Legend

- Railroad
- Major Water
- Zoning Line
- Sections

Zoning Districts

- A-1
- A-2
- A-3
- R-E
- R-1-A
- R-1-C
- R-2
- R-3
- R-4
- M-H
- C-0
- C-1
- C-2
- C-3
- C-4
- C-5
- I-1
- I-2
- I-3
- CO
- PL
- AV
- DIA
- P-U-D
- P-U-D(P)

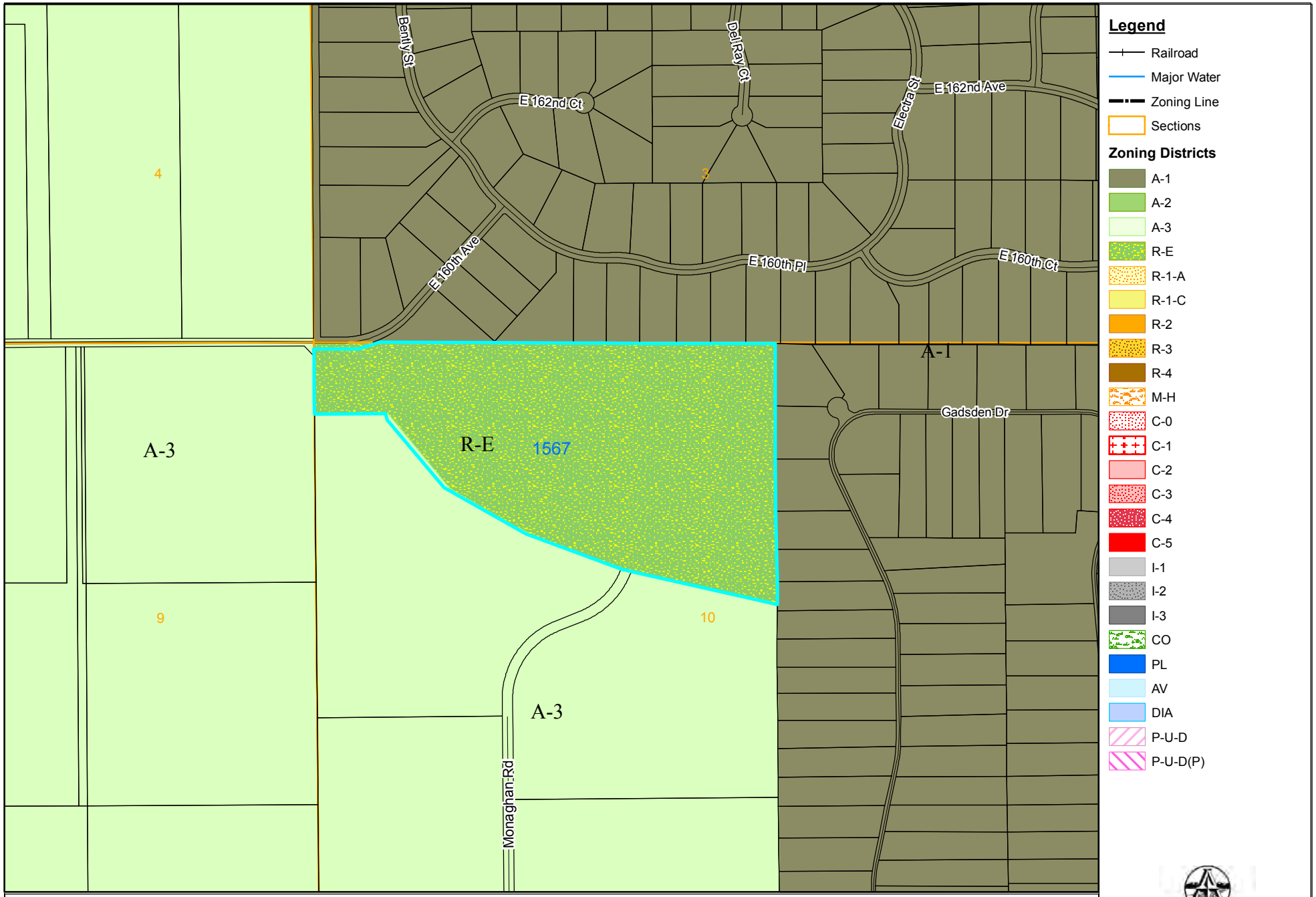
PLT2019-00026; Ridgeview Estates, Filing No. 1

Aerial Map

N

For display purposes only.

ADAMS COUNTY COLORADO



PLT2019-00026; Ridgeview Estates, Filing No. 1

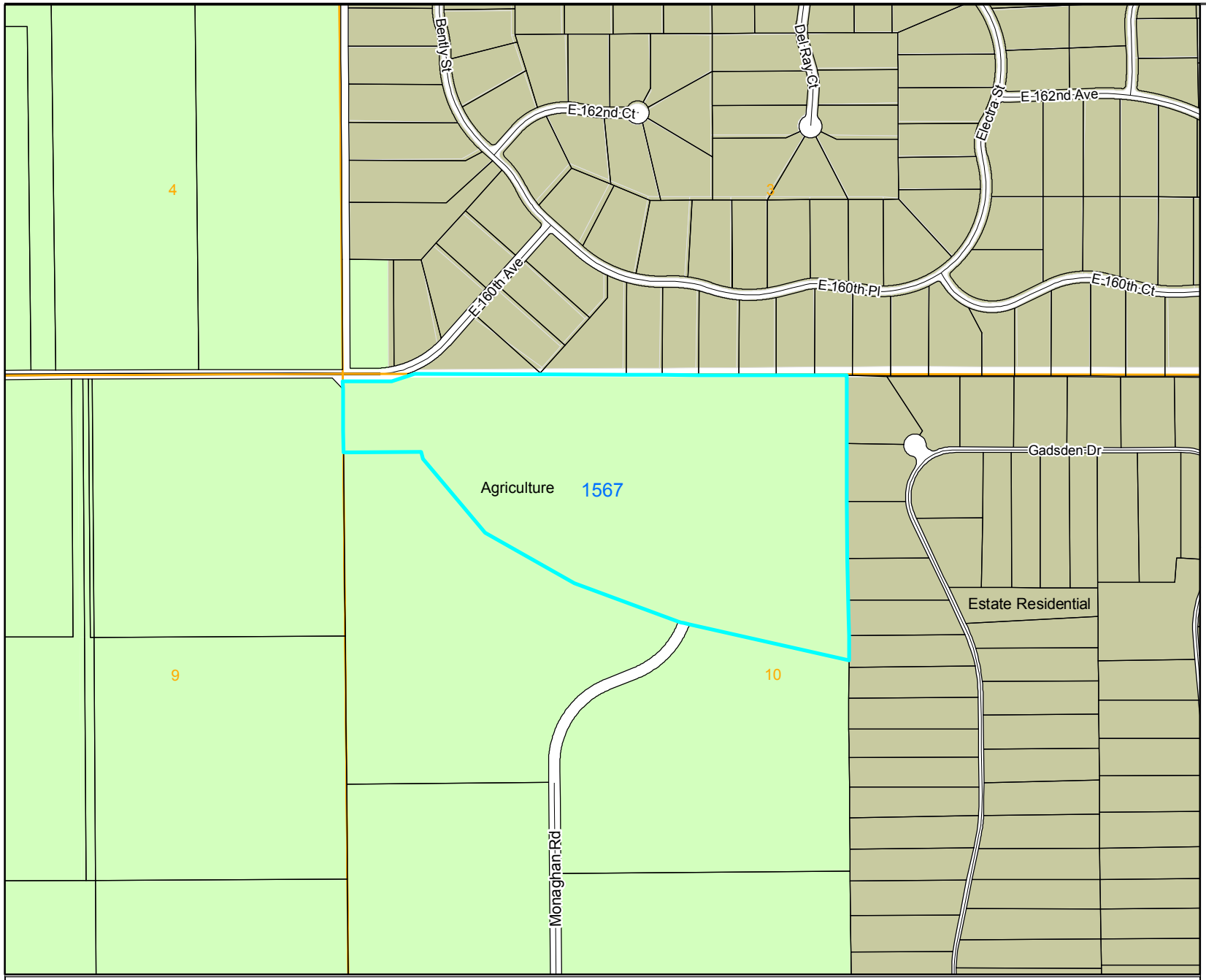
Current Zoning Map

N

For display purposes only.

ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy



Legend

Future Landuse 2012 (Rev2016)

Residential
- Urban Residential
- Estate Residential

Mixed Use
- Local District Mixed Use
- Mixed Use Neighborhood
- Activity Center
- Mixed Use Employment

Commercial/Industrial
- Commercial
- Industrial

Other
- Agriculture
- DIA Reserve
- Parks and Open Space
- Public
- Municipal Area

PLT2019-00026; Ridgeview Estates, Filing No. 1

Future Land Use

N

For display purposes only.

ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

August 21, 2019

Greg Barnes
Adams County Planner
4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, Co. 80601

Ref: Ridgeview Estates
Final Plat Submittal
E. 160th Ave.
Adams Co, Colorado

Dear Greg:

Please accept this letter as a written explanation of our request and a general overview of the Ridgeview Estates Subdivision in Adams County, Colorado.

Ridgeview Estates is a 21-lot subdivision located south of E 160th Ave., just west of Great Rock South subdivision and south of Great Rock North subdivision. The property is currently zoned residential estates (RE). This subdivision will be in and utilizing the Great Rock North Water District for public water.

Access will be provided from E 160th Ave. and all homes will be located out of the DIA noise overlay district.

We anticipate final platting the property in December and constructing the utilities and roads in early 2020. Home construction would begin early in 2020.

Please review the enclosed "Final Major Subdivision Submittal" and issue any comments you may have.

If you have any questions, please contact us.

Sincerely,

David Moore, P.E.
Alliance Consulting

RIDGEVIEW ESTATES - FILING NO. 1

CASE # PLT2019-00026

A PORTION OF THE NORTHWEST 1/4 OF SECTION 10,
TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M.,
COUNTY OF ADAMS, STATE OF COLORADO.
SHEET 1 OF 2
FINAL PLAT

DEDICATION AND OWNERSHIP:

KNOW ALL MEN BY THESE PRESENTS, THAT RIDGEVIEW ESTATES LLC, A COLORADO LIMITED LIABILITY COMPANY, BEING THE OWNER OF A PORTION OF THE NORTHWEST QUARTER OF SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:
BEGINNING AT THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., THENCE S 00°05'13" E ALONG THE EAST LINE OF THE WEST HALF OF SECTION 10, WITH ALL BEARINGS CONTAINED HEREIN RELATIVE THERETO, A DISTANCE OF 1495.68 FEET;
THENCE DEPARTING SAID EAST LINE OF THE NORTHWEST QUARTER OF SECTION 10, N 76°50'50" W, A DISTANCE OF 903.48 FEET;
THENCE N 69°27'56" W A DISTANCE OF 596.98 FEET;
THENCE N 60°05'53" W A DISTANCE OF 537.87 FEET;
THENCE N 39°37'58" W A DISTANCE OF 507.03 FEET;
THENCE N 17°26'04" W A DISTANCE OF 38.65 FEET;
THENCE N 90°00'00" W A DISTANCE OF 406.46 FEET, TO A POINT ON THE EAST LINE OF THE NORTHEAST QUARTER OF SECTION 9;
THENCE ALONG SAID EAST LINE OF THE NORTHEAST QUARTER OF SAID SECTION 9, N 00°07'50" W A DISTANCE OF 373.61 FEET, TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND DESCRIBED IN BOOK 4431 PAGE 118, COUNTY PUBLIC RECORDS;
THENCE ALONG THE SOUTH LINE OF SAID PARCEL, THE FOLLOWING TWO (2) COURSES:
1) S 89°23'03" E PARALLEL WITH AND 40.00 FEET SOUTH OF, BY PERPENDICULAR MEASUREMENT, THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10, A DISTANCE OF 257.32 FEET;
2) THENCE N 72°13'56" E A DISTANCE OF 126.83 FEET, TO A POINT ON THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10;
THENCE ALONG SAID NORTH LINE OF THE WEST HALF OF SECTION 10, S 89°23'03" E, A DISTANCE OF 2267.15 FEET TO THE POINT OF BEGINNING;
CONTAINING AN AREA OF 2,713,728 SQUARE FEET OF 62.299 ACRES MORE OR LESS.

HAVE BY THESE PRESENTS LAID OUT, PLATTED, AND SUBDIVIDED THE SAME INTO LOTS, STREETS, TRACTS, AND EASEMENTS AS SHOWN ON THIS PLAT UNDER THE NAME AND STYLE OF "RIDGEVIEW ESTATES – FILING NO. 1" THE UNDERSIGNED DOES HEREBY DEDICATE, GRANT AND CONVEY TO ADAMS COUNTY, STATE OF COLORADO, THOSE PUBLIC EASEMENTS, TRACTS, ALL STREETS AND OTHER PUBLIC WAYS AND LANDS AS SHOWN ON THIS PLAT; AND FURTHER RESTRICTS THE USE OF OF ALL PUBLIC EASEMENTS TO ADAMS COUNTY AND/OR ITS ASSIGNS, PROVIDED HOWEVER, THAT THE SOLE RIGHT AND AUTHORITY TO RELEASE OR QUITCLAIM ALL OR ANY SUCH PUBLIC EASEMENT SHALL REMAIN EXCLUSIVELY VESTED IN ADAMS COUNTY, AND ALSO RESERVE THOSE PORTIONS OF REAL PROPERTY WHICH ARE LABELED AS UTILITY AND DRAINAGE EASEMENTS ON THIS PLAT, FOR THE INSTALLATION AND MAINTENANCE OF UTILITIES AND DRAINAGE FACILITIES, INCLUDING BUT NOT LIMITED TO ELECTRIC LINES, GAS LINES, TELEPHONE LINES, WATER LINES, SEWER LINES; TOGETHER WITH A PERPETUAL RIGHT OF INGRESS AND EGRESS FOR THE INSTALLATION, MAINTENANCE, AND REPLACEMENT OF SUCH LINES; SAID EASEMENTS AND RIGHTS TO BE UTILIZED IN A RESPONSIBLE AND PRUDENT MANNER.
EXECUTED THIS ___ DAY OF _____ 20__.

_____ _____ AS _____ _____
NAME TITLE DATE
BY: RIDGEVIEW ESTATES, A COLORADO LIMITED LIABILITY COMPANY

ACKNOWLEDGMENT:

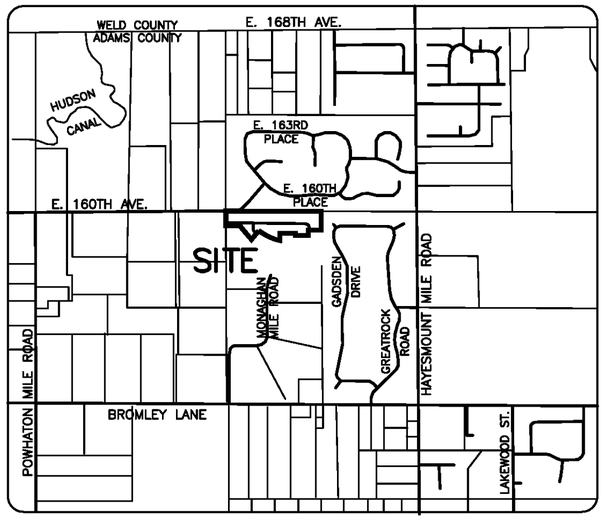
STATE OF COLORADO)
) SS
COUNTY OF ADAMS)

THE FORGOING OWNERSHIP CERTIFICATE WAS ACKNOWLEDGED BEFORE ME THIS ___ DAY OF _____, 20__,

BY _____.

_____
NOTARY PUBLIC

WITNESS MY HAND AND OFFICIAL SEAL.
MY COMMISSION EXPIRES _____



VICINITY MAP
SCALE: 1" = 3,000'

BOARD OF COUNTY COMMISSIONERS APPROVAL

APPROVED BY THE ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS
THIS___DAY OF_____ 20__.

_____
CHAIR

CLERK AND RECORDER'S CERTIFICATE

ACCEPTED FOR FILING IN THE OFFICE OF THE CLERK AND RECORDER OF THE COUNTY OF ADAMS THIS ___ DAY OF _____, 20__, AT _____ O'CLOCK _M..

_____ _____ _____
ADAMS COUNTY CLERK AND RECORDER BY: DEPUTY CLERK

_____
RECEPTION NUMBER

SURVEYOR'S CERTIFICATION:

I, ROBERT A. RICKARD, A DULY LICENSED PROFESSIONAL LAND SURVEYOR, REGISTERED IN THE STATE OF COLORADO DO HEREBY CERTIFY THAT THERE ARE NO ROADS, PIPELINES, IRRIGATION DITCHES, OR OTHER EASEMENTS IN EVIDENCE OR KNOWN BY ME TO EXIST ON OR ACROSS THE HEREIN BEFORE DESCRIBED PROPERTY EXCEPT AS SHOWN ON THIS PLAT. I FURTHER CERTIFY THAT I HAVE PERFORMED THE SURVEY SHOWN HEREON, OR SUCH SURVEY WAS PREPARED UNDER MY DIRECT RESPONSIBILITY AND SUPERVISION, THAT THIS PLAT ACCURATELY REPRESENTS SAID SURVEY, AND THAT ALL MONUMENTS EXIST AS SHOWN HEREIN.

_____ _____
ROBERT A. RICKARD, PLS NO. 28283 DATE
FOR AND ON BEHALF OF
ROCK CREEK SURVEYING, LLC

NOTES:

1. ACCORDING TO COLORADO LAW YOU MUST COMMENCE ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY WITHIN THREE YEARS AFTER YOU FIRST DISCOVER SUCH DEFECT IN NO EVENT, MAY ANY ACTION BASED UPON ANY DEFECT IN THIS SURVEY BE COMMENCED MORE THAN TEN YEARS FROM THE DATE OF THE CERTIFICATION SHOWN HEREON.
2. BASIS OF BEARINGS: THE EAST LINE OF THE WEST HALF OF SEC. 10, T.1S., R.65W. OF THE 6TH P.M. ASSUMED TO BEAR S00°05'13"E BETWEEN A FOUND 3/4 INCH REBAR WITH 2 INCH ALUMINUM CAP STAMPED LS 25937 AT THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH PRINCIPAL MERIDIAN AND A FOUND NO. 5 REBAR WITH A 1.5 INCH YELLOW PLASTIC CAP STAMPED LS 29414 ON THE EAST LINE OF SAID NORTHEAST QUARTER OF SECTION 10 AT THE NORTHEAST CORNER OF PARCEL 4 RECORDED IN BOOK 1 AT PAGE 2779 AS RECEPTION NO. 2005-118.
3. ANY PERSON WHO KNOWINGLY REMOVES, ALTERS OR DEFACES ANY PUBLIC LAND SURVEY MONUMENT OF LAND BOUNDARY MONUMENT OR ACCESSORY, COMMITS A CLASS TWO (2) MISDEMEANOR PURSUANT TO STATE STATUTE 18-4-508, C.R.S.
4. THE SUBJECT PROPERTY IS NOT WITHIN A DESIGNATED F.E.M.A. FLOOD PLAIN AS DETERMINED BY THE FLOOD INSURANCE RATE MAP, COMMUNITY PANEL NUMBER 08001C036J, EFFECTIVE DATE SEPTEMBER 28, 2018.
5. EXPANSIVE SOILS ARE KNOWN TO EXIST ON THIS SITE. WHERE THESE CONDITIONS ARE FOUND TO EXIST, THE RECOMMENDATION OF A QUALIFIED SOILS ENGINEER SHALL BE FOLLOWED IN THE DESIGN AND CONSTRUCTION OF THE FOUNDATIONS AND FOOTINGS.
6. THE HOMEOWNER'S ASSOCIATION SHALL BE CREATED AND IN PLACE PRIOR TO RECORDING OF THIS PLAT.
7. ADAMS COUNTY IS NOT RESPONSIBLE FOR THE ENFORCEMENT OF PRIVATE COVENANTS, CONDITIONS, AND RESTRICTIONS.
8. ACCESS FOR ALL LOTS SHALL BE FROM THE INTERNAL ROAD SYSTEM.
9. FOURTEEN (14') WIDE UTILITY AND DRAINAGE EASEMENTS ARE HEREBY GRANTED ON PRIVATE PROPERTY ADJACENT TO ALL PUBLIC STREETS IN THE SUBDIVISION OR PLATTED AREA. THESE EASEMENTS ARE DEDICATED FOR THE INSTALLATION, MAINTENANCE, AND REPLACEMENT OF ELECTRIC, GAS, CABLE, AND TELECOMMUNICATIONS FACILITIES. UTILITIES SHALL ALSO BE PERMITTED WITHIN ANY ACCESS EASEMENTS IN THE SUBDIVISION. PERMANENT STRUCTURES AND WATER METERS SHALL NOT BE PERMITTED WITHIN SAID UTILITY EASEMENTS.
10. D.I.A. NOISE IMPACTS MAY BE PREVALENT IN THIS SUBDIVISION. THE PROPERTY IS LOCATED NORTH OF THE 60LDN NOISE CONTOUR. NOISE IMPACTS ASSOCIATED WITH DENVER INTERNATIONAL AIRPORT, VAN AIRE SKYPORT, AND OTHER PUBLIC AND PRIVATE AIRPORTS MAY BE PREVALENT IN THIS SUBDIVISION.
11. ROCK CREEK SURVEYING, LLC, HAS RELIED UPON THE PROPERTY INFORMATION BINDER ORDER NO. IN70593905 PREPARED BY LAND TITLE GUARANTEE COMPANY, EFFECTIVE DATE 12/7/2018 AT 5:00 P.M., FOR THE RESEARCH OF EASEMENTS, RIGHTS-OF-WAY, ENCUMBRANCES AND OTHER MATTERS OF RECORD AFFECTING THE SUBJECT PROPERTY. THIS SURVEY AND PLAT DOES NOT CONSTITUTE A TITLE SEARCH BY ROCK CREEK SURVEYING, LLC., TO DETERMINE OWNERSHIP OR APPLICABLE EASEMENTS AND RIGHTS-OF-WAY.
12. MEASURED VALUES THAT DIFFER FROM RECORDED VALUES SHOULD BE DENOTED WITH (M). RECORDED VALUES SHOULD BE DENOTED WITH (R).
13. DRAINAGE EASEMENTS AS SHOWN ON THE PLAT ARE DEDICATED TO AND WILL BE MAINTAINED BY THE HOMEOWNER'S ASSOCIATION FOR THE PURPOSE OF PROVIDING STORM WATER DRAINAGE THROUGHOUT THE SUBDIVISION AND FOR THE MAINTENANCE THEREOF. DRAINAGE EASEMENTS SHALL BE KEPT CLEAR OF OBSTRUCTIONS TO THE FLOW AND/OR TO OBSTRUCTIONS TO MAINTENANCE ACCESS. CONSTRUCTION OF STRUCTURES, INCLUDING BUT NOT LIMITED TO HOUSES, GARAGES, BARNS, FENCES AND SHEDS SHALL NOT BE PERMITTED WITHIN THE DESIGNATED DRAINAGE EASEMENT. ANY PERMITTED ROADS, DRIVEWAYS, LANDSCAPING OR OTHER IMPROVEMENTS OVER ANY DRAINAGE EASEMENTS MUST BE PROPERLY CONSTRUCTED IN ACCORDANCE WITH APPLICABLE ADAMS COUNTY REGULATIONS AND DRAINAGE CRITERIA.
14. THE POLICY OF THE COUNTY REQUIRES THAT MAINTENANCE ACCESS BE PROVIDED TO ALL STORM DRAINAGE FACILITIES TO ASSURE CONTINUOUS OPERATIONAL CAPABILITY OF THE SYSTEM. THE PROPERTY OWNERS SHALL BE RESPONSIBLE FOR THE MAINTENANCE OF ALL DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS LOCATED ON THEIR LAND UNLESS MODIFIED BY THE SUBDIVISION DEVELOPMENT AGREEMENT. SHOULD THE OWNER FAIL TO MAINTAIN SAID FACILITIES, THE COUNTY SHALL HAVE THE RIGHT TO ENTER SAID LAND FOR THE SOLE PURPOSE OF OPERATIONS AND MAINTENANCE. ALL SUCH MAINTENANCE COSTS WILL BE ASSESSED TO THE PROPERTY OWNERS.
15. THE COUNTY HAS THE RIGHT TO ENTER THE PROPERTY TO CONDUCT PERIODIC INSPECTIONS OF THE DRAINAGE FACILITIES.
16. TYPICAL SIGHT TRIANGLE EASEMENTS ARE RESTRICTED TO LANDSCAPING, FENCES, RETAINING WALLS, SIGNS (EXCEPT STREET SIGNS) AND ANY OTHER OBSTRUCTIONS THAT ARE NO MORE THAN 36 INCHES IN HEIGHT AS MEASURED FROM THE CROWN OF THE STREET INTERSECTION.
17. EQUESTRIAN EASEMENTS ARE HEREBY DEDICATED TO THE HOMEOWNER'S ASSOCIATION FOR THE PURPOSE OF MAINTAINING SAID EASEMENT AREAS AS AN EQUESTRIAN TRAIL USED BY THE ASSOCIATION MEMBERS AND GUESTS. WHEN EQUESTRIAN EASEMENTS OVERLAY DRAINAGE EASEMENTS, THE DRAINAGE EASEMENTS SHALL HAVE SENIOR RIGHT TO PRESERVE THE INTEGRITY OF DRAINAGE. NO FENCING IS ALLOWED WITHIN THE EQUESTRIAN EASEMENT EXCEPT THE EXTERIOR PERIMETER FENCE, ON THE BOUNDARY OF RIDGEVIEW ESTATES, PROVIDED AND MAINTAINED BY THE HOMEOWNER'S ASSOCIATION.
18. TRACT A IS FOR FUTURE WATER WELL ESTABLISHMENT BY GREAT ROCK NORTH WATER AND SANITATION DISTRICT AND SHALL BE OWNED AND MAINTAINED BY GREAT ROCK NORTH WATER AND SANITATION DISTRICT.
19. TRACT B FOR THE DETENTION POND SHALL BE OWNED AND MAINTAINED BY THE HOMEOWNER'S ASSOCIATION.
20. THE MONAGHAN MILE ROAD ACCESS TO THE SOUTH OF THIS SUBDIVISION SHALL BE FOR EMERGENCY VEHICLES ONLY. AN AUTOMATIC GATE SHALL BE INSTALLED PER THE GREATER BRIGHTON FIRE PROTECTION DISTRICT STANDARDS FOR RESTRICTED ACCESS GATES.
21. LINEAR UNITS ARE MEASURED IN U.S. SURVEY FEET.
22. KALLSEN 110 GAS WELL MOTORIZED ACCESS EASEMENT TO BE MAINTAINED BY THE HOA.
23. TRACT C IS INTENDED FOR FUTURE DEVELOPMENT OF RIDGEVIEW ESTATES.
24. A TEMPORARY ACCESS EASEMENT FOR THE PURPOSE OF INGRESS, EGRESS, MAINTENANCE, EMERGENCY ACCESS, AND PEDESTRIAN USE, THROUGH A PORTION OF A HAMMER HEAD ON DEER PARK STREET AND EAST 158TH DRIVE IS BEING DEDICATED BY THIS PLAT. SAID EASEMENT TO BE USED FOR TEMPORARY ACCESS UNTIL SUCH TIME AS THE ROAD IS EXTENDED BEYOND THE HAMMER HEAD, CONSTRUCTION OF THE ROAD IS COMPLETED, AND THE ROAD HAS BEEN DEDICATED TO AND ACCEPTED BY THE COUNTY, AT WHICH POINT THIS EASEMENT SHALL TERMINATE.

C:\USERS\PATRICK S DOMAGALL\DOCUMENTS\ALLIANCE CONSULTING\16030 RIDGEVIEW ESTATES\SURVEY\DWG\PH 1 FINAL-PLAT 18X24.DWG PLOTTED: 3/26/2020

FINAL PLAT – RIDGEVIEW ESTATES – FILING NO. 1
PART OF THE NW 1/4 OF SEC. 10, T1S, R65W OF THE 6TH P.M.,
COUNTY OF ADAMS, STATE OF COLORADO.

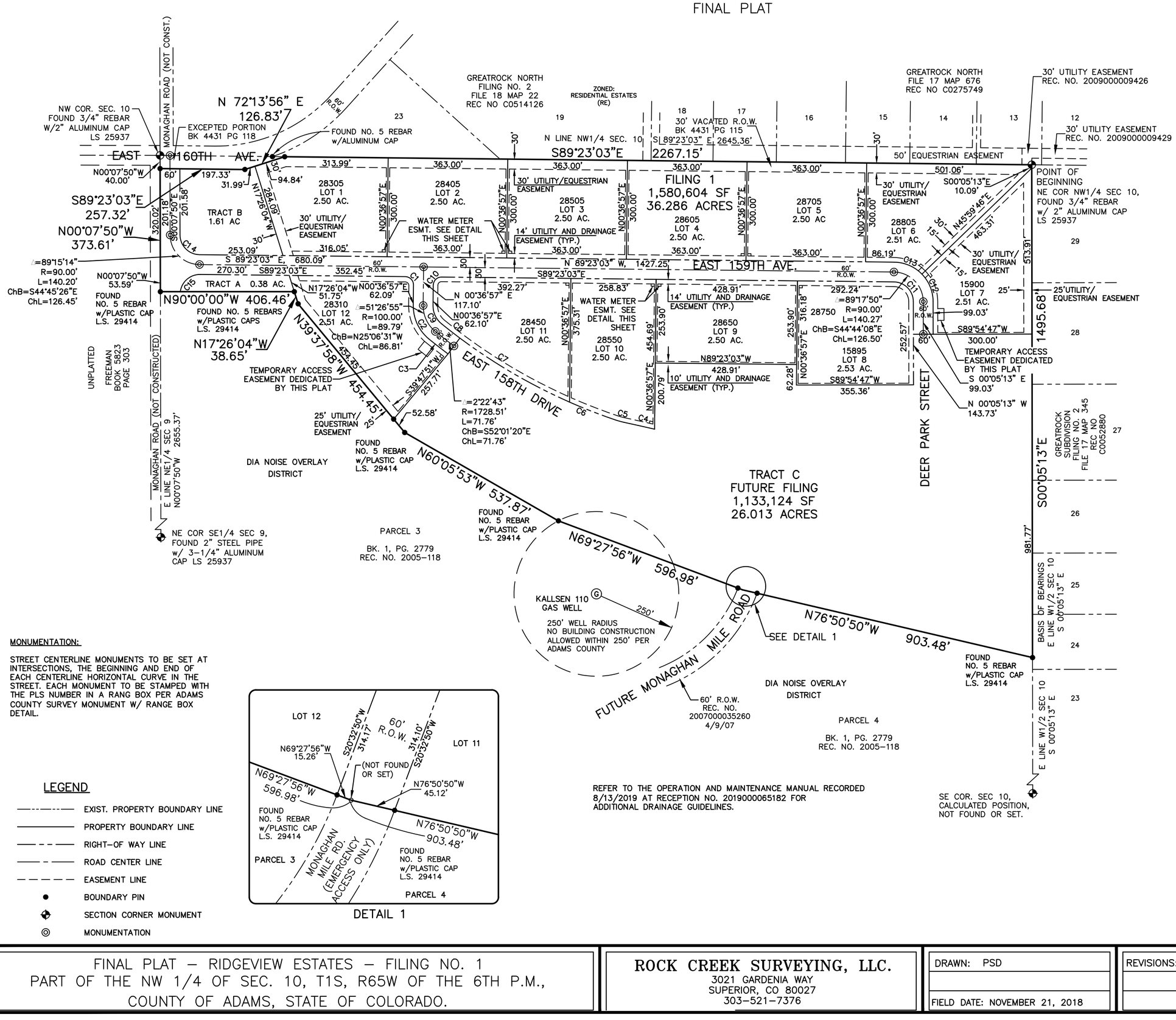
ROCK CREEK SURVEYING, LLC.
3021 GARDENIA WAY
SUPERIOR, CO 80027
303-521-7376

DRAWN: PSD	REVISIONS:	SCALE: 1" = 200'
FIELD DATE: NOVEMBER 21, 2018		DATE: MARCH 26, 2020

RIDGEVIEW ESTATES - FILING NO. 1

A PORTION OF THE NORTHWEST 1/4 OF SECTION 10,
TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M.,
COUNTY OF ADAMS, STATE OF COLORADO.
SHEET 2 OF 2
FINAL PLAT

CASE # PLT2019-00026



200 0 200 400

ORIGINAL SCALE: 1"=200'

CURVE TABLE				
CURVE	RADIUS	DELTA	LENGTH	CHORD
C1	25.00	90°00'00"	39.27	N44°23'03"W 35.36
C2	130.00	51°26'48"	116.73	S25°06'27"E 112.85
C3	1758.32	2°22'45"	73.01	S52°01'14"E 73.01
C4	5590.76	0°58'32"	95.18	N77°22'18"W 95.18
C5	220.00	6°31'07"	25.03	N74°36'00"W 25.02
C6	1698.51	5°06'09"	151.26	N68°47'22"W 151.21
C7	1698.51	13°01'35"	386.17	N59°17'02"E 383.43
C8	1698.51	2°22'43"	70.52	N52°01'20"E 70.51
C9	70.00	51°26'55"	62.86	S25°06'31"E 60.77
C10	25.00	90°00'00"	39.27	S45°36'57"W 35.36
C11	60.00	89°17'50"	93.51	N44°44'08"W 84.33
C12	120.00	44°02'44"	92.25	N22°06'35"W 89.99
C13	120.00	45°15'06"	94.77	N66°45'30"W 92.33
C14	60.00'	89°15'14"	93.47'	S44°45'26"E 84.30'
C15	60.00'	83°14'20"	87.17'	S48°59'47"W 79.70'

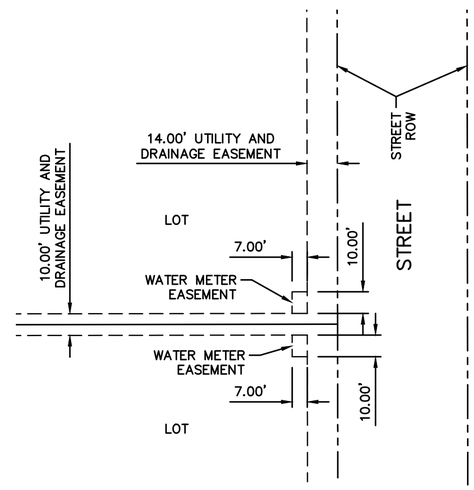
MONUMENTATION:

STREET CENTERLINE MONUMENTS TO BE SET AT INTERSECTIONS, THE BEGINNING AND END OF EACH CENTERLINE HORIZONTAL CURVE IN THE STREET. EACH MONUMENT TO BE STAMPED WITH THE PLS NUMBER IN A RANG BOX PER ADAMS COUNTY SURVEY MONUMENT W/ RANGE BOX DETAIL.

LEGEND

- EXIST. PROPERTY BOUNDARY LINE
- PROPERTY BOUNDARY LINE
- RIGHT-OF WAY LINE
- ROAD CENTER LINE
- EASEMENT LINE
- BOUNDARY PIN
- SECTION CORNER MONUMENT
- MONUMENTATION

DETAIL 1



TYPICAL WATER METER EASEMENT
N.T.S.

FINAL PLAT – RIDGEVIEW ESTATES – FILING NO. 1 PART OF THE NW 1/4 OF SEC. 10, T1S, R65W OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO.	ROCK CREEK SURVEYING, LLC. 3021 GARDENIA WAY SUPERIOR, CO 80027 303-521-7376	DRAWN: PSD FIELD DATE: NOVEMBER 21, 2018	REVISIONS:	SCALE: 1" = 200' DATE: MARCH 26, 2020

C:\USERS\PATRICK S DOMAGALL\DOCUMENTS\ALLIANCE CONSULTING\16030 RIDGEVIEW ESTATES\SURVEY\DWG\PH 1 FINAL-PLAT 18X24.DWG PLOTTED: 3/26/2020

RIDGEVIEW ESTATES
SUBDIVISION
Case No. PLT2019-00026

SUBDIVISION IMPROVEMENTS AGREEMENT

THIS AGREEMENT is made and entered into by and between the County of Adams, State of Colorado, hereinafter called "County," and Ridgeview Properties LLC, 5540 Ward Road Suite 230 Arvada, CO 80002, hereinafter called "Developer."

WITNESSETH:

WHEREAS, Developer is the owner of real property in the County of Adams, State of Colorado, as described in Exhibit "A" attached hereto, and by this reference made a part hereof.

WHEREAS, it is provided by resolution of the Board of County Commissioners, County of Adams, that where designated the Developer shall have entered into a written agreement with the County to install public and/or private improvements, and to deed land for public purposes or right-of-way.

NOW, THEREFORE, in consideration of the foregoing, the parties hereto promise, covenant, and agree as follows:

1. **Engineering Services**. Developer shall furnish, at its own expense, all engineering and other services in connection with the design and construction of the improvements described and detailed on Exhibit "B" attached hereto, and by this reference made a part hereof.

2. **Drawings and Estimates**. The Developer shall furnish drawings and cost estimates for all improvements described and detailed on Exhibit "B" for approval by the County. Upon request, the Developer shall furnish one set of reproducible "as built" drawings and a final statement of construction costs to the County.

3. **Construction**. Developer shall furnish and construct, at its own expense and in accordance with drawings and materials approved by the County, the improvements described and detailed on Exhibit "B".

4. **Time for Completion**. Improvements shall be completed according to the terms of this agreement within "construction completion date" appearing in Exhibit "B". The Director of Community and Economic Development Department may for good cause grant extension of time for completion of any part or all of improvements appearing on said Exhibit "B". Any extension greater than 180 days is within the sole discretion of the Board of County Commissioners. All extensions of time must be in writing.

5. **Guarantee of Compliance**. Developer shall furnish to the County a cash escrow deposit or other acceptable collateral, releasable only by the County, to guarantee compliance with this agreement. Said collateral shall be in the amount of $751,334 including twenty percent (20%) to cover administration and five percent (5%) per year for the term of the Agreement to cover inflation. Upon approval of the final plat, completion of said improvements constructed according to the terms of this agreement, and preliminary acceptance by the Director of Public Works in accordance with section 5-02-05-01 of the County's Development Standards and Regulations, the collateral shall be released. Completion of said improvements shall be determined solely by the County, and a reasonable part of said collateral, up to 20%, may be retained to guarantee maintenance of public improvements for a period of one year from the date of Preliminary Acceptance.

   No building permits shall be issued until said collateral is furnished in the amount required and in a form acceptable to the Board of County Commissioners, and until the final plat has been approved and the improvements described in Exhibit "B" have been preliminarily accepted by the Department of Public Works.

6. **Acceptance and Maintenance of Public Improvements**. All improvements designated "public" on Exhibit "B" shall be public facilities and become the property of the County or other public agencies upon acceptance. During the period of one year from and after the acceptance of public improvements, the Developer shall, at its own expense, make all needed repairs or replacement due to defective materials or workmanship which, in the opinion of the County, becomes necessary. If, within ten days of written notice to the Developer from the

County requesting such repairs or replacements, the Developer has not undertaken with due diligence to make the same, the County may make such repairs or replacements at the Developer's expense. In the case of an emergency such written notice may be waived.

7. **Successors and Assigns**. This agreement shall be binding upon the heirs, executors, personal representatives, successors, and assigns of the Developer, and shall be deemed a covenant running with the real property as described in Exhibit "A" attached hereto.

8. **Improvements and Dedication**. The undersigned Developer hereby agrees to provide the following improvements, and to dedicate described property.

A. **Improvements**.

Public Improvements:

Earthwork, sediment and erosion control, storm drainage, public road construction, dry utilities, surveying, engineering, testing and construction management (See Exhibit "B" for description, estimated quantities and estimated construction costs.)

Private Improvement: Driveway construction on 27910 E160th Avenue as shown on drawing C9 and included in Guarantee of Compliance.

The improvements shall be constructed in accordance with all County requirements and specifications in accordance with the approved plans and time schedule as indicated in Exhibit "B".

B. **Public dedication of land for right-of-way purposes or other public purpose**. Upon approval of this agreement by the Board of County Commissioners, the Developer hereby agrees to convey by warranty deed to the County of Adams the following described land for right-of-way or other public purposes:

Road right of ways consisting of East 159th Avenue, Deer Park Street and East 158th Place.

[SIGNATURE PAGES TO FOLLOW]

Ridgeview Properties LLC
5440 Ward Road Suite 230
Arvada, CO 80002
720-907-9778

By: _____
Chad Ochsner
Ridgeview Properties LLC, Manager

By: _____
David Moore
Ridgeview Properties LLC, Manager

The foregoing instrument was acknowledged before me this _____ day of _____, 2020, by _____
_____.

My commission expires:_____

Address: _____
_____

_____
Notary Public

APPROVED BY resolution at the meeting of _____, 2020.

Collateral to guarantee compliance with this agreement and construction of public improvements shall be required in the amount of $751,334. No building permits shall be issued until said collateral is furnished in the amount required and in a form acceptable to the Board of County Commissioners and until the improvements described in Exhibit "B" have been preliminarily accepted.

ATTEST:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____
Clerk of the Board

_____
Chair

EXHIBIT A

Legal Description:

LEGAL DESCRIPTION

KNOW ALL MEN BY THESE PRESENTS, THAT RIDGEVIEW ESTATE LLC, A COLORADO CORPORATION, BEING THE OWNER OF A PORTION OF THE WEST HALF OF SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:
BEGINNING AT THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., THENCE S 00°05'13" E ALONG THE EAST LINE OF THE WEST HALF OF SECTION 10, WITH ALL BEARINGS CONTAINED HEREON RELATIVE THERETO, A DISTANCE OF 1495.68 FEET;
THENCE DEPARTING SAID EAST LINE OF THE WEST HALF OF SECTION 10, N 76°50'50" W, A DISTANCE OF 903.48 FEET;
THENCE N 69°27'56" W A DISTANCE OF 596.98 FEET;
THENCE N 60°05'53" W A DISTANCE OF 537.87 FEET;
THENCE N 39°37'58" W A DISTANCE OF 507.03 FEET;
THENCE N 17°26'04" W A DISTANCE OF 38.65 FEET;
THENCE N 90°00'00" W A DISTANCE OF 406.46 FEET, TO A POINT ON THE EAST LINE OF THE NORTHEAST QUARTER OF SECTION 9;
THENCE ALONG SAID EAST LINE OF THE NORTHEAST QUARTER OF SAID SECTION 9, N 00°07'50" W A DISTANCE OF 373.61 FEET, TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND DESCRIBED IN BOOK 4431 PAGE 18, COUNTY PUBLIC RECORDS;
THENCE ALONG THE SOUTH LINE OF SAID PARCEL, THE FOLLOWING TWO (2) COURSES:
1) S 89°23'03" E PARALLEL WITH AND 40.00 FEET SOUTH OF, BY PERPENDICULAR MEASUREMENT, THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10, A DISTANCE OF 257.32 FEET;
2) THENCE N 72°13'56" E A DISTANCE OF 126.83 FEET, TO A POINT ON THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10;
THENCE ALONG SAID NORTH LINE OF THE WEST HALF OF SECTION 10, S 89°23'03" E, A DISTANCE OF 2267.15 FEET TO THE POINT OF BEGINNING;
CONTAINING AN AREA OF 2,713,709 SQUARE FEET OF 62.298 ACRES MORE OR LESS.

EXHIBIT B

Public Improvements: Street Name/s

Description	Est. Quantity	Est. Unit Cost	Est. Construct. Cost

See Ridgeview Estates Exhibit B Spreadsheet

Construction Completion Date: August 31, 2021

Initials or signature of Developer:_____

Ridgeview Properties LLC

RIDGEVIEW ESTATES EXHIBIT B

Date 6/9/2020

FILING 1

Completion Date 8-31-21	Qty	Unit	Unit Price	Total Cost	Admin Fee 20%	Yearly Fee 5%	TOTAL COST
ONSITE CONSTRUCTION - PREPARATION & EARTHWORK							
MOBILIZATION	1	LS	$1,500.00	$1,500	$300	$90	$1,890
REMOVAL OF FENCING	1	LS	$800.00	$800	$160	$48	$1,008
STRIPPING AND GRUBBING 4 INCHES	6200	CY	$1.75	$10,850	$2,170	$651	$13,671
BALANCE (OVERLOT) NET FILL GRADING	9970	CY	$2.00	$19,940	$3,988	$1,196	$25,124
EROSION CONTROL SILT FENCE	5500	LF	$1.50	$8,250	$1,650	$495	$10,395
RESPREAD TOPSOIL	3000	CY	$1.75	$5,250	$1,050	$315	$6,615
MISC SUBGRADE PREP, CLEANUP,& TRASH REM	1	LS	$1,500.00	$1,500	$300	$90	$1,890
TOTAL - ONSITE PREPARATION AND EARTHWORK				**$48,090**	**$9,618**	**$2,885**	**$60,593**
CONSTRUCTION - SEDIMENT AND EROSION CONTROL							
MOBILIZATION	1	LS	$1,000.00	$1,000	$200	$60	$1,260
SILT FENCE	4325	LF	$1.50	$6,488	$1,298	$389	$8,175
STABILIZED CONSTRUCTION ENTRANCE	1	LS	$2,101.00	$2,101	$420	$126	$2,647
EQUIPMENT STORAGE AREA	1	EA	$500.00	$500	$100	$30	$630
MATERIAL STORAGE AREA	1	EA	$500.00	$500	$100	$30	$630
EROSION LOG	1050	LF	$5.00	$5,250	$1,050	$315	$6,615
INLET PROTECTION	1	EA	$220.00	$220	$44	$13	$277
OUTLET PROTECTION	8	EA	$220.00	$1,760	$352	$106	$2,218
SEDIMENT BASIN	1	EA	$550.00	$550	$110	$33	$693
CONCRETE WASHOUT	1	EA	$671.00	$671	$134	$40	$845
TOTAL - SEDIMENT AND EROSION CONTROL				**$19,040**	**$3,808**	**$1,142**	**$23,990**
CONSTRUCTION - ONSITE STORM DRAINAGE							
18" RCP (OFFSITE DRIVEWAY)	44	LF	$100.00	$4,400	$880	$264	$5,544
18" END SECTION (OFFSITE DRIVEWAY)	2	EA	$563.00	$1,126	$225	$68	$1,419
24"RCP	227	LF	$120.00	$27,240	$5,448	$1,634	$34,322
24" END SECTION	7	EA	$650.00	$4,550	$910	$273	$5,733
36" RCP	79	LF	$220.00	$17,380	$3,476	$1,043	$21,899
19x30 RCP	145	LF	$220.00	$31,900	$6,380	$1,914	$40,194
24x38 RCP	174	LF	$240.00	$41,760	$8,352	$2,506	$52,618
24x38 END SECTION	2	LF	$850.00	$1,700	$340	$102	$2,142
TYPE 'D' OUTLET BOX W/ MICRO POOL	1	EA	$5,784.00	$5,784	$1,157	$347	$7,288

Completion Date 8-31-21	Qty	Unit	Unit Price	Total Cost	20%	5%	COST
CONCRETE OUTLET PIPE HEADWALLS	10	CY	$300.00	$3,000	$600	$180	$3,780
BURIED RIP RAP	300	TN	$40.00	$12,000	$2,400	$720	$15,120
RIPRAP	59	TN	$32.00	$1,888	$378	$113	$2,379
NATIVE SEED MIX - DISTURBED AREA AND DETENTION POND	13	AC	$900.00	$11,700	$2,340	$702	$14,742
TOTAL - ONSITE STORM DRAINAGE				**$164,428**	**$32,886**	**$9,866**	**$207,179**
CONSTRUCTION - ONSITE PAVING							
MOBILIZATON	1	LS	$2,500.00	$2,500	$500	$150	$3,150
STREET GRADING & PREP.	12708	SY	$2.60	$33,041	$6,608	$1,982	$41,631
4" CL 6 SUBGRADE BASE	1426	TN	$16.00	$22,816	$4,563	$1,369	$28,748
STREET PAVING 3" COURSE BASE	1361	TN	$55.00	$74,855	$14,971	$4,491	$94,317
6' SHOULDER ROAD BASE	1001	TN	$16.00	$16,016	$3,203	$961	$20,180
DRIVEWAY REALIGNMENT ROAD BASE (OFFSITE DRIVEWAY)	136	TN	$16.00	$2,176	$435	$131	$2,742
VALVE ADJUSTMENT	12	EA	$225.00	$2,700	$540	$162	$3,402
ACCESS ROADS	830	LF	$10.00	$8,300	$1,660	$498	$10,458
STREET SIGNS	4	EA	$400.00	$1,600	$320	$96	$2,016
TOP LIFT PAVING (in one year)	1361	TN	$55.00	$74,855	$14,971	$4,491	$94,317
TOTAL - ONSITE PAVING				**$238,859**	**$47,772**	**$14,332**	**$300,962**
ONSITE UTILITIES							
ELECTRICITY (P.S. CO.)	12	LS	$4,000.00	$48,000	$9,600	$2,880	$60,480
GAS (P.S. CO.)	12	LS	$665.00	$7,980	$1,596	$479	$10,055
TELEPHONE (U.S. WEST)	12	LS	$450.00	$5,400	$1,080	$324	$6,804
CONDUITS	1	LS	$5,000.00	$5,000	$1,000	$300	$6,300
TOTAL - ONSITE UTILITIES				**$66,380**	**$13,276**	**$3,983**	**$83,639**
ONSITE SPECIAL ITEMS AND FEES							
MONUMENT SIGN	1	EA	$3,500.00	$3,500	$700	$210	$4,410
SURVEYING	1	EA	$18,000.00	$18,000	$3,600	$1,080	$22,680
ENGIINEERING	1	EA	$12,000.00	$12,000	$2,400	$720	$15,120
TESTING	1	EA	$6,000.00	$6,000	$1,200	$360	$7,560
CONSTRUCTION MANAGEMENT	1	EA	$20,000.00	$20,000	$4,000	$1,200	$25,200
TOTAL - ONSITE SPECIAL ITEMS & FEES				**$59,500**	**$11,900**	$3,570	**$74,970**
TOTAL COSTS				**$596,297**	**$119,259**	**$35,778**	**$751,334**

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Development Review Team Comments

Date: November 6, 2019
Project Number: PLT2019-00026
Project Name: **Ridgeview Estates, Filing No. 1**

Note to Applicant:
The following review comments and information from the Development Review Team is based on the information you submitted for your Final Plat application. The Development Review Team review comments may change if you provide different information during the Resubmittal. At this time, a resubmittal is being required. Resubmittal material can be deposited with our One-Stop Customer Service Center. You will need the attached "Resubmittal Form", and a paper and digital copy of all the resubmitted material. You should also provide a written response to each staff comment and referral agency letter. Please contact the case manager if you have any questions.

Also, please note where "Section" is referenced, it is referring to the appropriate section of the Adams County Development Standards and Regulations.

Your review comment consultation will be held on ***11/25/2019 from 3:00-3:45 p.m.***

Commenting Division: **Development Services, Planning**
Name of Reviewer: Layla Bajelan
Email: LBajelan@adcogov.org / 720-523-6863

PLN01: REQUEST

a. Final Plat for 12 single-family residential lots within the Ridgeview Estates Subdivision.
b. Subdivision Improvement Agreement (SIA)

PLN02: SITE LOCATION/ZONING/COMPREHENSIVE PLAN

a. Subject parcel is zoned as Residential Estate (RE)
b. Future Land Use is Agriculture.
c. Subject property is within the Airport Height Overlay for DIA. Prior to the issuance of any building permits, all property owners will be required to complete the following:
    1. A signed and recorded aviation easement must be filed prior to issuance of a building permit.
    2. Property owner must complete an FAA Aeronautical study on obstructions to determine if the proposed development could be a hazard to air navigation.

PLN03: CRITERIA FOR APPROVAL

Section 2-02-18-03-05

The Planning Commission, in making their recommendation, and the Board of County Commissioners, in approving a final plat, shall find.

1. The final plat is consistent and conforms to the approved preliminary plat.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

PLN04: PUBLIC LAND DEDICATION

a. Public Land Dedication- School District, Neighborhood/ Regional Parks
b. Cash in Lieu being required
c. Included is a calculation sheet of PLD fees, once your case has been scheduled for Public Hearing, you will be expected to pay $8,738.22, at least 24 hours before your case has been scheduled.
d. Please do not pay this amount until your case has been scheduled for Public Hearing

PLN06: WATER SUPPLY

a. Please see attached letter from the Colorado Department of Water Resources, regarding your water supply.
b. Adequate Water Supply has been established through the Great Rock North Water and Sanitation District.

PLN07: PUBLIC UTILITIES (XCEL)

a. The Utility Master Plan does not appear to match the plat.

PLN08: ENGINEERING PLANS

a. Cannot schedule for Public Hearing until Engineering plans are approved.

PLN09: Section 2-02-18-03-05; #7 Subdivision Improvements Agreement

a. Applicant applied for an Amendment to Subdivision Improvement Agreement and not for the Subdivision Improvement Agreement.
b. Applicant must fill out attached SIA application and turn in an SIA.
c. A SIA will be required with the final plat.

PLN10: Planning Comments

a. The County does not allow for phasing. Applicant must resubmit all documents that mention phasing with new documents that reflect filings rather than phasings.
b. In all resubmittals please change the case manager name from Greg Barnes to Layla Bajelan.
c. Please address all staff, referral agency, and public comments. Referral Agency comments are listed below.

PLN11: Referral Agency Comments (Letters are attached to this PDF)

a. Xcel Energy- Discrepancies from preliminary plat. The Utility Master Plan does not appear to match the plat.
b. Brighton Fire and Rescue will require a secondary access to East 159th if phasing is allowed.
c. CO Department of Natural Resources, Parks and Wildlife

Commenting Division: Development Services, Engineering:
Name of Review: Greg Labrie
Email: GLabrie@adcogov.org **/ 720-523-6824**

ENG01: The Adams County Development Standards and Regulations are very clear that Phasings are not allowed in Subdivision Construction. This subdivision should be divided in filings and not phases.
ENG02: A Subdivision Improvement Agreement will be required with appropriate collateral. This agreement must be approved by the BoCC. No building permits for these lots will be issued until these roadways have been constructed and have received Preliminary Acceptance.
ENG03: No construction will be allowed to take place without the approved SIA.
ENG04: No construction will be allowed until a Construction Permit has been issued for this work and a Pre-Construction Meeting has taken place.
ENG05: A utility Detection System will be required for all underground utility systems, including the storm sewer system. These standards and specifications should be included within these plans.
ENG06: A Pavement Thickness Design will be required prior to beginning construction. Due to the soils conditions in this area, a subgrade stabilization design may be required as well.
ENG07: Sheet C3, C9, C10 – The existing driveway shown at the S.W. Corner of 160th Ave. and 159th Ave. must be completely removed after the completion of construction. Please ensure that this driveway construction is accounted for in the SIA.
ENG08: Sheet C3, C4, C5, C6, C13 – A Temporary Cul-De-Sac will be required at Deer Park St. and E. 159th Ave.
ENG09: Sheet C4, C5, C6 – Access to lots 3 and 10 will be extremely difficult due to the steep grades along these frontages.
ENG10: Why are the Fire Hydrants not being constructed at the back side of the shoulders?

ENG11: Sheet C15 – An Access Culvert is required at 159th Ave. where the waterline turns north and ties into E. 160th Ave. An Access Culvert at this intersection point should be required to allow for the outfall of the Detention Pond.

Commenting Division: Development Services, Right-of-Way
Name of Review: Marissa Hillje
Email. mhillje@adcogov.org / 720-523-6837

ROW1. Remove all labels that state PHASE or Phasing.
ROW2. Edit Title of plat- see redlines
ROW3. Future Filing 2 should be put into a tract- see redlines
ROW4. Add note about Future Filling 2 Tract C on Sheet 1- see redlines
ROW5. Change Case No on top right – see redlines
ROW6. Temporary Access easement for cul-de-sacs should be dedicated to the county either by plat or separate instrument.
ROW7. Change East 158th PLACE to DRIVE
ROW8. Add addresses to the plat- see redlines
ROW9: See redlines on plat attached

Commenting Division: Development Services, Addressing
Name of Review: Marissa Hillje
Email. **mhillje@adcogov.org / 720-523-6837**

ADD01: Addresses are assigned on the plat- see redlines

Commenting Division: Development Services Building and Safety, Chief Building Official
Name of Review: Justin Blair
Email: jblair@adcogov.org / 720-523-6843

No Comment

Commenting Division: Parks
Name of Review: Aaron Clark
Email: aclark@adcogov.org

No Comment

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Development Review Team Comments

Date: March 27, 2020
Project Number: PLT2019-00026
Project Name: Ridgeview Estates, Filing No.1

Note to Applicant:
The following review comments and information from the Development Review Team is based on the information you submitted for the Major Subdivision-Final Plat Application. The Development Review Team review comments may change if you provide different information during the Resubmittal. At this time, a resubmittal is being required.

Commenting Division: **Development Services, Planning**
Name of Reviewer: Layla Bajelan
Email: LBajelan@adcogov.org **/ 720-523-6863**

PLN01: No further planning comments.

Applicant will have to address the comments provided by the Adams County finance department (attached). Please submit the SIA in word version.

Commenting Division: Development Services, Engineering:
Name of Review: Greg Labrie
Email: GLabrie@adcogov.org **/ 720-523-6824**

ENG01: Page 2 or 5, last paragraph of the SIA, the collateral amount should be changed to $770,185 as indicated in Exhibit B.

ENG02: The construction completion date shall be pushed out to the maximum time allowed which is April 2021. Please add the construction completion date to Exhibit B and change the construction completion date in the SIA.

Commenting Division: Development Services, Planning (RIGHT-OF-WAY Review)
Name of Review: Holden Pederson
Email. HPederson@adcogov.org **/ 720-523-6847**

ROW01: Applicant has addressed all plat comments.

From:	Krysti Stehle
To:	Layla Bajelan
Cc:	Laura Garcia
Subject:	RE: PLT2019-00026; Ridgeview Estates, Filing No. 1 SIA
Date:	Wednesday, March 04, 2020 8:23:15 AM
Attachments:	Ridgeview Estates PLT2019-00026.xlsx PLT2019-00026; Ridgeview Estates, Filing No. 1 SIA.pdf

Hello,

Please change the Exhibit tables to only show the Quantity, Unit Price and Total columns (if you need an example please let me know). The 20% and 5% can be added as a total at the end.

Item number 5 the collateral calculated should be $751,333,34 not $770,185. Please see attached spreadsheet for the calculation.

I forgot to include that if the project goes over one year then an additional 5% is to be added on.

Thank you,

Krysti Stehle
Accountant I, Finance Department
4430 South Adams County Parkway, Suite C4000A
Brighton, CO 80601-8212
720.523.6822 | kstehle@adcogv.org

From: Laura Garcia <LGarcia@adcogov.org>
Sent: Monday, March 2, 2020 12:55 PM
To: Layla Bajelan <LBajelan@adcogov.org>
Cc: Krysti Stehle <KStehle@adcogov.org>
Subject: FW: PLT2019-00026; Ridgeview Estates, Filing No. 1 SIA

No worries. Can you please start adding Krysti to all emails.

Thanks and have a great day.

Laura Garcia
Senior Accountant, *Finance*
4430 South Adams County Parkway, 4th floor, Suite C4228
Brighton, CO 80601
720.523.6239 | Lgarcia@adcogov.org | adcogov.org

EXHIBIT B

quantity	amount	total	
1.00	1,500.00	1,500.00	
1.00	800.00	800.00	
6,200.00	1.75	10,850.00	
9,970.00	2.00	19,940.00	
5,500.00	1.50	8,250.00	
3,000.00	1.75	5,250.00	
1.00	1,500.00	1,500.00	48,090.00
1.00	1,000.00	1,000.00	
4,325.00	1.50	6,487.50	
1.00	2,101.00	2,101.00	
1.00	500.00	500.00	
1.00	500.00	500.00	
1,050.00	5.00	5,250.00	
1.00	220.00	220.00	
8.00	220.00	1,760.00	
1.00	550.00	550.00	
1.00	671.00	671.00	19,039.50
44.00	100.00	4,400.00	
2.00	563.00	1,126.00	
227.00	120.00	27,240.00	
7.00	650.00	4,550.00	
79.00	220.00	17,380.00	Difference on your spreadsheet
145.00	220.00	31,900.00	
174.00	240.00	41,760.00	
2.00	850.00	1,700.00	
1.00	5,784.00	5,784.00	
10.00	300.00	3,000.00	
300.00	40.00	12,000.00	
59.00	32.00	1,888.00	
13.00	900.00	11,700.00	164,428.00
1.00	2,500.00	2,500.00	
12,708.00	2.60	33,040.80	
1,426.00	16.00	22,816.00	
1,361.00	55.00	74,855.00	
1,001.00	16.00	16,016.00	
136.00	16.00	2,176.00	
12.00	225.00	2,700.00	
830.00	10.00	8,300.00	
4.00	400.00	1,600.00	
1,361.00	55.00	74,855.00	238,858.80
12.00	4,000.00	48,000.00	
12.00	665.00	7,980.00	
12.00	450.00	5,400.00	
1.00	5,000.00	5,000.00	66,380.00
1.00	3,500.00	3,500.00	

1.00	18,000.00	18,000.00	
1.00	12,000.00	12,000.00	
1.00	6,000.00	6,000.00	
1.00	20,000.00	20,000.00	59,500.00

Cost Estimate from Exhibit B	596,296.30
Additional 20% for Administration	119,259.26
Total Cost with 20% Admin	715,555.56
Additional 5% per year of Total Cost with 20% Admin	35,777.78
Total	751,333.34

From: BFR Plan Reviews
To: Layla Bajelan
Subject: RE: Request for Comments; PLT2019-00026 Ridgeview Estates Phase I, Final Plat
Date: Friday, November 01, 2019 2:41:07 PM

Good afternoon,

If phasing is allowed the Fire District will require a secondary access to East 159th Avenue.

Thank you!

Carla Gutierrez
Fire Inspector
Brighton Fire Rescue District
500 S. 4th Ave. 3rd Floor
Brighton, CO 80601
303-654-8042
www.brightonfire.org

From: Layla Bajelan <LBajelan@adcogov.org>
Sent: Wednesday, October 16, 2019 4:42 PM
To: Layla Bajelan <LBajelan@adcogov.org>
Cc: Christine Fitch <CFitch@adcogov.org>; Marissa Hillje <MHillje@adcogov.org>; Gordon Stevens <GStevens@adcogov.org>; Justin Blair <jblair@adcogov.org>; Aaron Clark <AClark@adcogov.org>; Rick Reigenborn <RReigenborn@adcogov.org>; smiller@adcogov.org; Lisa Culpepper <LCulpepper@adcogov.org>; BFR Plan Reviews <planreviews@brightonfire.org>; kmonti@sd27j.org; brandyn.wiedrich@centurylink.com; Eric Guenther <EGuenther@adcogov.org>; joanna.williams@state.co.us; eliza.hunholz@state.co.us; serena.rocksund@state.co.us; CGS_LUR@mines.edu; thomas_lowe@cable.comcast.com; ljohnson@sdmsi.com; Gail Moon <GMoon@adcogov.org>; Quinn, Chris <Chris.Quinn@RTD-Denver.com>; mdeatrich@tchd.org; Land Use <LandUse@tchd.org>; mary.c.dobyns@usps.gov; George, Donna L <Donna.L.George@xcelenergy.com>
Subject: Request for Comments; PLT2019-00026 Ridgeview Estates Phase I, Final Plat

Request for Comments

Case Name:	Ridgeview Estates Phase I, Final Plat
Case Number:	PLT2019-00026

From:	Gutierrez, Carla
To:	Layla Bajelan
Subject:	RE: PLT2019-00026; Ridgeview Estates Filing No. 1, Final Plat 2nd Submittal- Request for Comments
Date:	Monday, January 06, 2020 8:44:35 AM
Attachments:	image001.png

Good morning Layla,

The Fire District has no further questions or concerns at this time. Our previous concerns regarding access have been addressed.

Thank you!

Carla Gutierrez
Fire Inspector
Brighton Fire Rescue District
500 S. 4th Ave – 3rd Floor
Brighton CO 80601
Office: 303.659.8042 / Cell: 720-684-7669
www.brightonfire.org

From: Layla Bajelan <LBajelan@adcogov.org>
Sent: Thursday, January 2, 2020 11:00 AM
To: George, Donna L <Donna.L.George@xcelenergy.com>; Jill Carlson <carlson@mines.edu>; serena.rocksund@state.co.us; Lisa Johnson <ljohnson@sdmsi.com>; Samantha Riblett <sriblett@UnitedPower.com>; Gutierrez, Carla <CGutierrez@brightonfire.org>; Gordon Stevens <GStevens@adcogov.org>; Lisa Johnson <ljohnson@sdmsi.com>
Subject: PLT2019-00026; Ridgeview Estates Filing No. 1, Final Plat 2nd Submittal- Request for Comments

Request for Comments-2nd Submittal

Case Name:	Ridgeview Estates Filing No. I, Final Plat-2nd submittal
Case Number:	PLT2019-00026

January 2, 2020

The Adams County Planning Commission is requesting comments on the following application:

COLORADO GEOLOGICAL SURVEY

1801 Moly Road
Golden, Colorado 80401

October 31, 2019

Karen Berry
State Geologist

Layla Bajelan
Adams County
Community & Economic Development
4430 S. Adams County Parkway, Suite W2000A
Brighton, CO 80601

Location:
NW¼ Section 10,
T1S, R65W of the 6th P.M.
39.9855, -104.6543

Subject: **Ridgeview Estates (PLT2019-00026)**
Adams County, CO; CGS Unique No. AD-19-0015_2

Dear Ms. Bajelan:

Colorado Geological Survey has reviewed the Ridgeview Estates Phase 1 final plat referral, for 12 residential lots of approximately 2.5 acres each. CGS previously reviewed Ridgeview Estates at major subdivision preliminary plat (PLT2018-00044, 21 lots); our comments were provided in a letter dated January 24, 2019. No geologic or geotechnical information was included with the current or previous Ridgeview Estates referral documents, and the lot layout does not appear to have changed, so our previous comments remain valid:

> The site does not contain steep slopes, is not undermined, is located within an "area of minimal flood hazard," and is not exposed to any identified geologic hazards that would preclude the proposed residential use and density. **CGS therefore has no objection to approval.**
>
> **Mineral resource potential.** According to the Atlas of Sand, Gravel, and Quarry Aggregate Resources, Colorado Front Range Counties (Schwochow et al, Colorado Geological Survey Special Publications 5-A and 5-B, 1974, Plate 2 and Mile High Lakes Quadrangle, respectively), the site is mapped as containing an "E3" resource, described as a wind-deposited fine aggregate, "Sands: includes sands ranging from coarse gravelly stream sands to fine-grained wind-deposited dune sands." A determination regarding whether the mapped sands constitute an economically viable mineral resource is outside the scope of CGS review.

Thank you for the opportunity to review and comment on this project. If you have questions or require additional review, please call me at (303) 384-2643, or e-mail carlson@mines.edu.

Sincerely,

Jill Carlson, C.E.G.
Engineering Geologist

COLORADO
Parks and Wildlife
Department of Natural Resources

Northeast Regional Office
6060 Broadway
Denver, CO 80216
P 303.291.7227

October 27, 2019

Layla Bajelan
Adams County Community and Economic Development Department
4430 South Adams County Parkway
Suite W2000A
Brighton, CO 80601-8216

RE: Ridgeview Estates Phase I, Final Plat (PLT2019-00026)

Dear Ms. Bajelan:

Thank you for the opportunity to comment on the Ridgeview Estates Phase I, final plat. The mission of Colorado Parks and Wildlife (CPW) is to perpetuate the wildlife resources of the state, to provide a quality state parks system, and to provide enjoyable and sustainable outdoor recreation opportunities that educate and inspire current and future generations to serve as active stewards of Colorado's natural resources. Our goal in responding to land use proposals such as this is to provide complete, consistent, and timely information to all entities who request comment on matters within our statutory authority.

The proposed 21-lot subdivision on 36.286-acres is located south of East 160th Avenue, just west of Great Rock South Subdivision and south of Great Rock North Subdivision, Adams County, Colorado (Parcel # 0156710200001). The proposed Ridgeview Estate Phase I plan is currently surrounded by residential single-family homes and open agricultural lands.

District Wildlife Manager Serena Rocksund recently visited this site. The main impacts to wildlife from this development is fragmentation and loss of habitat along the Eastern Plains.

CPW would expect a variety of wildlife species to utilize this site on a regular basis, most notably, small to mid-sized mammals, songbirds, and raptors. The potential also exists for large mammals, such as deer and pronghorn, to frequent this site.

Raptors

For further information on ways to minimize impact on raptors, a copy of the document "Recommended Buffer Zones and Seasonal Restrictions for Colorado Raptors[1]," is available from your local District Wildlife Manager. Following the recommendations outlined in this document will decrease the likelihood of unintentional take of nesting raptors through disturbance.

[1] Copies of Raptors Buffer are available at:
https://cpw.state.co.us/Documents/WildlifeSpecies/LivingWithWildlife/RaptorBufferGuidelines2008.pdf

Prairie Dogs

If prairie dog colonies are present, CPW would recommend they either be captured alive and moved to another location or humanely euthanized before any earth-moving occurs. The possibility of live-trapping and donating to a raptor rehabilitation facility or the black-footed ferret recovery program is another reasonable option. If interested, please contact the local District Wildlife Manager. Be aware that a permit and approval from CPW is required for live relocation.

Burrowing Owls

If a prairie dog colony is discovered within the project area, the potential may also exist for the presence of burrowing owls. These raptors are classified as a state threatened species and are protected by both state and federal laws, including the Migratory Bird Treaty Act. Therefore, if any earth-moving will begin between March 15th and October 31st, a burrowing owl presence/absence survey[2],” should be performed.

Human-wildlife Conflict

Future residents should be informed by the HOA that wildlife such as fox, coyotes, beavers, and raccoons might frequent the development area in search of food and cover. Coyotes, foxes, cottontail rabbits, and raccoons are several species that have adapted to living in urban environments.

CPW recommends that people moving into and residing in this area take the proper precautions to prevent unnecessary conflicts between people and pets with wildlife. Due to the potential for human-wildlife conflicts associated with this project, please consider the following recommendations when educating future homeowners about the existence of wildlife in the area:

- Pet foods and bowls should be kept indoors.
- Garbage should be kept in secure containers to minimize its attractiveness to wildlife. Trash should be placed in containers with tight seals and remain indoors until the morning of pickup.
- Feeding of wildlife, with the exception of birds, is illegal.

For further information, Colorado Parks and Wildlife can provide copies of the following brochures[3]: “Your Guide to Avoiding Human-Coyote Conflicts”, “Don’t Feed the Wildlife”, and “Too Close for Comfort: Avoiding Conflicts with Wildlife in the City” to residents of the surrounding open space.

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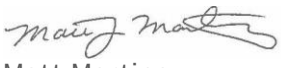
[2] Copies of Burrowing Owl Survey are available at:
https://cpw.state.co.us/Documents/WildlifeSpecies/LivingWithWildlife/RecommendedSurveyOwls.pdf

[3] Copies of Living with Wildlife Brochures are available at:
http://cpw.state.co.us/learn/Pages/LivingwithWildlife.aspx

Thank you again for the opportunity to comment on the proposed Ridgeview Estates Phase I, final plat. Please do not hesitate to contact us again about ways to continue managing the property in order to maximize wildlife value while minimizing potential conflicts. If you have any further questions, please contact District Wildlife Manager Serena Rocksund at (303) 291-7132 or serena.rocksund@state.co.us.

Sincerely,



Matt Martinez
Area 5 Wildlife Manager

Cc: M. Leslie, T. Kroening, S. Rocksund

COLORADO
Division of Water Resources
Department of Natural Resources

October 30, 2019

Layla Bajelan
Adams County Planning and Development
Transmission via email:
LBajelan@adcogov.org

RE: Ridgeview Estates Phase I, Final Plat
Case No. PLT2019-00026
NW ¼ Sec. 10, T1S, R65W, 6th P.M.
Water Division 1, Water Districts 1 and 2

Dear Mr. Barnes,

We have reviewed your October 16, 2019 referral related to Phase I of Ridgeview Estates Subdivision, which represent a portion of Ridgeview Estates Development. Ridgeview Estates Subdivision Phase I is a proposed subdivision on about 36.286 acres that will be subdivided into 12-2.5 acre single-family residential lots. This office previously provided comments on the Ridgeview Estates Development by our letters dated January 9, 2019, February 5, 2019, April 30, 2019, and May 13, 2019.

Water Supply Demand

The water supply demand for Phase I was not provided, however according to a Water Supply Adequacy Evaluation for Ridgeview Estates Development dated May 3, 2019 ("water supply letter") from Mr. Paul Bruss of Bishop Brogden and Associates ("BBA") previously provided to this office the water supply demand for Ridgeview Estates Development is estimated at 0.55 acre-feet/year/lot. Based on that amount the total demand for Phase I would be 6.6 acre-feet/year. The water will be used for in-house use (based on an estimated amount of 0.3 acre-feet/year/residence), lawn and garden irrigation of up to 4,000 square-feet of lawn and garden/residence (based on an estimated amount of 0.05 acre-feet/year/1,000 square-feet of lawn and garden) and the watering of up to five horses/lot (based on 2 horses/acre on average 2.5 acre lots and an estimated amount of 0.01 acre-feet/year/horse or similar livestock).

Source of Water Supply

The proposed water supplier for Phase I was not provided, however according to the May 3, 2019 BBA water supply letter, Greatrock North Water and Sanitation District ("District") is listed as the water supplier Ridgeview Estates Development. An inclusion agreement of the Ridgeview Estates Development parcel (62.3 acre) within the District's boundaries was previously provided to this office. As part of the inclusion agreement the District will require that all not nontributary and nontributary water underlying the 62.3 acre parcel be deeded to the District. The BBA water supply letter estimated the amounts of water that may be available underlying the 62.3-acre parcel. The amounts that will ultimately be deeded to the District will be the amounts determined by the adjudication in the water court of the ground water available underlying the 62.3 acre parcel. We note that since this water has not yet been adjudicated by the water court, and decreed augmentation plans have not been obtained for the not nontributary Denver and Upper Arapahoe aquifers, this water cannot be considered by our office as part of the water available to the District as part of their firm water supply. The District previously indicated that it has sufficient nontributary capacity in its current system to supply a 300-year water supply to the Ridgeview Estates Subdivision and its existing developments.

According to the BBA water supply letter the District currently has 450 acre-feet of nontributary or augmented not nontributary water available to the District, as shown in Table 1 below:

Table 1 – Denver Basin Water Availability

		Annual Available based on 100 year allocation approach (af/yr)						
Aquifer	Status	94CW142	98CW266	99CW40	00CW200	04CW17	07CW170	Total
Upper Arapahoe	NNT		19.04	9.75	30.9			59.69
Lower Arapahoe	NT	35.36*		21.35*	66.20*	21.5	5.7	150.11
Laramie-Fox Hills	NT	68.2		35.8	105.20	23.5	7.5	240.20

NNT – Augmented not nontributary water.
*NT – **Nontributary water that has not reserved to replace post pumping depletions**.

The District also obtains water from alluvial wells pumped pursuant to the augmentation plans in case nos. 04CW247 and 08CW66. Under case no. 04CW247 alluvial wells are pumped to serve up to 244 individual residences within the Box Elder Creek Ranch Subdivision. The replacement source for the augmentation plan decreed in case nos. 04CW247 is a Laramie-Fox Hills aquifer well constructed into the Laramie-Fox Hills aquifer pursuant to case no. 00CW200. Under case no. 08CW66 alluvial wells are pumped to serve up to 322 residences within the boundaries of the Greatrock North Water and Sanitation District. One of the replacement sources for the augmentation plan decreed in case no. 08CW66 is the Denver Basin aquifer water adjudicated in case nos. 94CW142, 98CW266, 99CW40, 00CW200, 04CW17 and 07CW170.

An updated build-out demand that includes Ridgeview Estates Development and considers the county's 300 year water supply requirement was provided in the BBA water supply letter. BBA determined the District's build-out water demand based on the total number of lots at build-out for each subdivision and a water demand per lot for each subdivision. A summary of the number of lots and water demands for each subdivision are provided in Table 2 below:

Table 1 – Build-Out Water Requirements

Subdivision	Build-Out Number of Lots	Water Requirement (af/lot/yr)	Total Water Requirement from BBA
Greatrock North	131	0.43	56.3
Rocking Horse Farms	96	0.43	41.3
Box Elder Creek Ranch (1-3)	243	0.17	41.3
Hayesmount Estates	22	0.45	9.9
Homestead Heights	56	0.45	25.2
Ridgeview Estates	21	0.55	11.6
Total	569		185.6

The water requirement per lot for Greatrock North, Rocking Horse Farms and Box Elder Creek Ranch were determined based on historical water deliveries and actual lots served in each subdivision analyzed on a monthly basis from 2012 to 2018. For Hayesmount Estates, Homestead Heights and Ridgeview Estates the demand was based on the Adams County Standards. For Box Elder Creek Ranch the District only provides water for in-house use. For the remainder of the subdivisions water is provided for both in-house use and lawn and garden irrigation.

Due to the District's use of both Denver Basin water and alluvial water pumped under augmentation plans a spreadsheet model was created to determine the adequacy of the water supply at buildout. The spreadsheet model calculates the alluvial and Denver Basin well pumping required to meet the District's build-out water demands, and determines the net depletions from the District's alluvial well pumping after accounting for return flows from the District's water operations. Based on that spreadsheet model BBA determined that there would be adequate water at buildout to serve the existing subdivisions and Ridgeview Estates Development.

The proposed source of water for this subdivision is a bedrock aquifer in the Denver Basin. The State Engineer's Office does not have evidence regarding the length of time for which this source will be a physically and economically viable source of water. According to 37-90-137(4)(b)(I), C.R.S., "Permits issued pursuant to this subsection (4) shall allow withdrawals on the basis of an aquifer life of one hundred years." Based on this **allocation** approach, the annual amounts of water shown in Table 2 above is equal to one percent of the total amount, as determined by rules 8.A and 8.B of the Statewide Nontributary Ground Water Rules, 2 CCR 402-7. Therefore, the water may be withdrawn in those annual amounts for a maximum of 100 years.

In the Adams *County Development Standards and Regulations*, Effective April 15, 2002, Section 5-04-05-06-04 states:

> "Prior to platting, the developer shall demonstrate that…the water supply is dependable in quantity and quality based on a minimum useful life of three-hundred (300) years. A minimum 300-year useful life means the water supply from both a static and dynamic basis will be viable for a minimum 300-year period. The static analysis shall include evaluation of the volume of water that is appropriable for the proposed subdivision. The dynamic analysis shall evaluate whether the appropriable water supply is sustainable for three-hundred (300) years, giving consideration to the location and extent of the aquifer, as well as impacts caused by both current and future pumping by others from the aquifer."

The State Engineer's Office does not have evidence regarding the length of time for which this source will be "dependable in quantity and quality." According to the BBA letter the only subdivisions subject to the 300 year water requirement is Homestead Heights, Hayesmount Estates, and Ridgeview Estates. Treating Adams County's requirement as an **allocation** approach based on three hundred years, the allowed average annual amounts of available water shown in Table 1 above would be reduced to account for the water requirements of Homestead Heights, Hayesmount Estates, and Ridgeview Estates subdivisions. The BBA water supply report shows that after accounting for the water supply for the Greatrock North, Rocking Horse Farms and Box Elder Creek Ranch there will be approximately 103.7 acre-feet of excess supplies from the existing subdivisions as available supplies in addition to the decree water in Lower Arapahoe and the Laramie Fox Hills aquifers (adjusted to 300 years) in case nos. 04CW17 (Homestead Heights) and 07CW170 (Haysmount Estates) to meet the 300 year water demands for Homestead Heights, Hayesmount Estates, and Ridgeview Estates.

The applicant should be aware that any proposed detention pond for this Phase I of the development must meet the requirements of a "storm water detention and infiltration facility" as defined in section 37-92-602(8), Colorado Revised Statutes, the structure may be subject to administration by this office. The applicant should review DWR's *Administrative Statement Regarding the Management of Storm Water Detention Facilities and Post-Wildland Fire Facilities in Colorado*, to ensure that the notification, construction and operation of the proposed structure meets statutory and administrative requirements. The applicant is encouraged to use *Colorado Stormwater Detention and Infiltration Facility Notification Portal*, located at https://maperture.digitaldataservices.com/gvh/?viewer=cswdif, to meet the notification requirements.

State Engineer's Office Opinion

Based upon the above and pursuant to Section 30-28-136(1)(h)(I) and Section 30-28-136(1)(h)(II), C.R.S., it is our opinion that the proposed water supply for Ridgeview Estates Phase I is adequate and can be provided without causing injury to decreed water rights.

Our opinion that the water supply is **adequate** is based on our determination that the amount of water required annually to serve the subdivision is currently physically available, based on current estimated aquifer conditions.

Our opinion that the water supply can be **provided without causing injury** is based on our determination that the amount of water that is legally available on an annual basis, according to the statutory **allocation** approach, for the proposed uses is greater than the annual amount of water required to supply existing water commitments and the demands of the proposed subdivision.

Our opinion is qualified by the following:

The Division 1 Water Court has retained jurisdiction over the final amount of water available under the decrees reference by the District, pending actual geophysical data from the aquifer.

The amounts of water in the Denver Basin aquifers, and identified in this letter, are calculated based on estimated current aquifer conditions. For planning purposes the county should be aware that the economic life of a water supply based on wells in a given Denver Basin aquifer may be less than the 100 years or 300 years used for allocation due to anticipated water level declines. We recommend that the county determine whether it is appropriate to require development of renewable water resources for this subdivision to provide for a long-term water supply.

Should you have any questions, please contact Ioana Comaniciu of this office at 303-866-3581 x8246.

Sincerely,

Joanna Williams
Water Resource Engineer

Ec: Subdivision file 26761

MEMORANDUM

TO: Lisa Johnson, District Manager, Greatrock North Water and Sanitation District

FROM: Brad Simons, MMI Water Engineers, LLC

RE: Final Plat Review Comments for Ridgeview Estates Phase I (PLT2019-00026)

DATE: November 1, 2019; **Revised November 7, 2019**

CC: Jennifer Tanaka, District General Counsel

This memorandum revises my comments provided on November 1, 2019, based upon communications with the District's General Counsel and additional research into the application for Ridgeview Estates Phase I (PLT2019-00026).

I have reviewed the submittal for the above referenced case received by MMI Water Engineers, LLC on October 17, 2019 and offer the following comments for consideration in the Greatrock North Water and Sanitation District's response to the Adams County Community & Economic Development Department:

1. The "LIENHOLDER CERTIFICATE" on Sheet 1 or 2 for "Phase 1 – Ridgeview Estates" indicates the District will "consent to the dedication and easements shown on this plat and release the same from the encumbrance recorded at Reception No. 2018000097841 of the records of the Adams County Clear and Recorder". A copy of the Statement of Lien is included for reference. The District should only execute the "LIENHOLDER CERTIFICATE" if the applicant pays the unpaid system development fees. Otherwise, said system development fees are due and owed on each single-family residential equivalent unit within five (5) business days of the issuance of a building permit by Adams County for that specific single-family residential equivalent unit and the District should not execute the "LIENHOLDER CERTIFICATE".
2. The cover sheet for "Phase 1 – Ridgeview Estates" indicates a Homeowner's Association will be created and will have a number of responsibilities:

   > Note 6: The Homeowner's Association shall be created and in place prior to recording of this plat.

Note 13: Drainage easements as shown on the plat are dedicated to and will be maintained by the Homeowner's Association for the purpose of providing storm water drainage throughout the subdivision and for the maintenance thereof.

Note 17: Equestrian easements are hereby dedicated to the Homeowner's Association for the purpose of maintaining said easement areas as an equestrian trail used by the Association members and guests. No fencing is allowed within the equestrian easements except the exterior perimeter fence, on the boundary of Ridgeview Estates, provided and maintained by the Homeowner's Association.

Note 18: Tract A is for future water well establishment by Great Rock North Water and Sanitation District and shall be owned and maintained by the Homeowner's Association.

Note 19: Tract B for the detention pond shall be owned and maintained by the Homeowner's Association.

Note 22: Kallsen 110 Gas Well motorized access easement to be maintained by the HOA.

The District has previously communicated concerns to Adams County regarding the enforcement of plat conditions (i.e. Notes) in the event a Homeowner's Association dissolves. The County has indicated it does not regulate Homeowner's Associations and that if an Association dissolves, the responsibilities revert to the individual homeowners. The District needs to formalize its concerns in writing to the County as the conditions above cause me concern.

3. Note 20 on Sheet 1 or 2 for "Phase 1 – Ridgeview Estates" indicates the Monaghan Mile Road access to the south of this subdivision shall be for emergency vehicles only and that an automatic gate shall be installed per the Greater Brighton Fire Protection District standards for restricted access gates. The future Monaghan Mile Road access road should extend to the end of Deer Park Street.
4. The lot numbering on Sheet 2 of 2 for "Phase 1 – Ridgeview Estates" is not consistent with the "Preliminary Plat" (PLT2018-00044).
5. The District should require separately recorded instruments (i.e. Utility Easement Agreements) for the dedication of non-exclusive utility easements for the construction, reconstruction, repair, replacement, and/or removal of water improvements and appurtenance thereto across Lot 1, Lot 6, and Lot 7. A copy of the District's form of Utility Easement Agreement is attached for reference.
6. The applicant needs to confirm the "50' Equestrian Easement" in the Greatrock North subdivision as shown on the "Master Utility Plan" allows for the construction of water improvements to Tract A of the Greatrock North subdivision.

I have also attached my review comments for PLT2018-00044, dated January 23, 2019, for additional reference.

Should you have any comments or questions, please contact me at 720-234-8398.

Electronically Recorded RECEPTION#: 2018000097841,
12/6/2018 at 3:22 PM, 1 OF 6,
REC: $38.00
TD Pgs: 0 Stan Martin, Adams County, CO.

After Recordation Please Return to
White Bear Ankele Tanaka & Waldron
2154 E. Commons Avenue, Suite 2000
Centennial, Colorado 80122

STATEMENT OF LIEN

TO ALL WHOM IT MAY CONCERN:

KNOW YE, that the Greatrock North Water and Sanitation District, a quasi-municipal corporation and political subdivision of the State of Colorado (the "Lien Claimant"), wishes to avail itself of the provisions of the statute in such cases made and provided and makes the following statement of lien:

FIRST: That the name of the owners or reputed owners of such properties to be charged with the lien are as follows:

See Exhibit A, attached hereto and incorporated herein by this reference

SECOND: That the name and mailing address of the Lien Claimant claiming the lien is:

Greatrock North Water and Sanitation District
c/o Special District Management Services, Inc.
141 Union Boulevard, Suite 150
Lakewood, Colorado 80228

THIRD: That the properties to be charged with such lien are described as follows:

See Exhibit B, attached hereto and incorporated herein by this reference

Situated in the County of Adams, State of Colorado.

FOURTH: That said lien is held for and on account of unpaid system development fees (the "System Development Fee") due to the Lien Claimant on the properties described in **Exhibit B** pursuant to statutory authority and the Resolution of the Board of Directors of the Greatrock North Water and Sanitation District Amending Rules and Regulations (2017 Reissuance) adopted on September 5, 2017.

FIFTH: That the amount of indebtedness due or owing the Lien Claimant for which said lien is claimed is $21,300.00 **per** single-family residential equivalent unit for each System Development Fee.

SEVENTH: That said System Development Fee is due and owing on each single-family residential equivalent unit within five (5) business days of the issuance of a building permit by Adams County for that specific single-family residential equivalent unit. Unpaid System Development Fees shall be subject to additional interest, costs of collections and attorneys' fees up until such time as payment in full is provided and a partial release is recorded for the specific single-family residential equivalent unit.

EIGHTH: That such lien is a statutory, perpetual lien.

Electronically Recorded RECEPTION#: 2018000097841,
12/6/2018 at 3:22 PM, 2 OF 6,
TD Pgs: 0 Stan Martin, Adams County, CO.

After Recordation Please Return to
White Bear Ankele Tanaka & Waldron
2154 E. Commons Avenue, Suite 2000
Centennial, Colorado 80122

LIEN CLAIMANT:
GREATROCK NORTH WATER AND SANITATION DISTRICT

By: _____
Jennifer Gruber Tanaka, Esq. Reg. No. 32056
White Bear Ankele Tanaka & Waldron

STATE OF COLORADO)
) ss.
COUNTY OF ARAPAHOE)

I, Jennifer Gruber Tanaka, Esq. being of lawful age and being first duly sworn upon oath, do say that I am legal counsel to Greatrock North Water and Sanitation District, the Lien Claimant herein named; that I have read the within Statement of Lien and amount of indebtedness and know the contents thereof; and that the same is true and correct, to the best of my knowledge, information and belief, and is made on behalf of the Lien Claimant.

_____
Jennifer Gruber Tanaka, Reg. No. 32056

Subscribed and sworn to before me in the County of Arapahoe, State of Colorado, this 6th day of December, 2018, by Jennifer Gruber Tanaka, as legal counsel for Greatrock North Water and Sanitation District.

My commission expires: 4-27-2019

Witness my hand and official seal.

_____
Notary Public

MEGAN MURPHY
NOTARY PUBLIC - STATE OF COLORADO
Notary Identification # 20154016648
My Commission Expires 4/27/2019

Electronically Recorded RECEPTION#: 2018000097841,
12/6/2018 at 3:22 PM, 3 OF 6,
TD Pgs: 0 Stan Martin, Adams County, CO.

EXHIBIT A
Ownership Record

Hayesmount Estates:

Salome Snider
Teresa Saenz and Adan Chaves
Vladimir Elizondo
Hector Faudoa
Anselmo Rodriguez
Marcos A. Rodriguez
Juan Blanco
Ismael Holguin

Ridgeview Estates:

Ridgeview Estates, LLC

Homestead Heights II:

Homestead Heights, LLC

Electronically Recorded RECEPTION#: 2018000097841,
12/6/2018 at 3:22 PM, 4 OF 6,
TD Pgs: 0 Stan Martin, Adams County, CO.

EXHIBIT B
Properties Charged with the Lien

Hayesmount Estates:

29635 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 1

29585 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 2

29515 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 3

29475 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 4

29425 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 5

29383 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 6

29343 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 7

29303 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 8

29265 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 9

29205 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 10

29151 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 11

29150 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 12

29200 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 13

29350 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 16

29460 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTEATES SUBDIVISION LOT: 18

29500 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 19

Electronically Recorded RECEPTION#: 2018000097841,
12/6/2018 at 3:22 PM, 5 OF 6,
TD Pgs: 0 Stan Martin, Adams County, CO.

29570 E 165th Avenue, Brighton, Colorado 80603 a/k/a SUB: HAYESMOUNT ESTATES SUBDIVISION LOT: 20

Ridgeview Estates:

PORTION OF THE WEST HALF OF SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:
BEGINNING AT THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., THENCE S 00°05'13" E ALONG THE EAST LINE OF THE WEST HALF OF SECTION 10, WITH ALL BEARINGS CONTAINED HEREON RELATIVE THERETO, A DISTANCE OF 1495.68 FEET;
THENCE DEPARTING SAID EAST LINE OF THE WEST HALF OF SECTION 10, N 76°50'50" W, A DISTANCE OF 903.48 FEET;
THENCE N 69°27'56" W A DISTANCE OF 596.98 FEET;
THENCE N 60°05'53" W A DISTANCE OF 537.87 FEET;
THENCE N 39°37'58" W A DISTANCE OF 507.03 FEET;
THENCE N 17°26'04" W A DISTANCE OF 38.65 FEET;
THENCE N 90°00'00" W A DISTANCE OF 406.46 FEET, TO A POINT ON THE EAST LINE OF THE NORTHEAST QUARTER OF SECTION 9;
THENCE ALONG SAID EAST LINE OF THE NORTHEAST QUARTER OF SAID SECTION 9, N 00°07'50" W A DISTANCE OF 373.61 FEET, TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND DESCRIBED IN BOOK 4431 PAGE 18, COUNTY PUBLIC RECORDS;
THENCE ALONG THE SOUTH LINE OF SAID PARCEL, THE FOLLOWING TWO (2) COURSES:
1) THENCE S 89°23'03" E PARALLEL WITH AND 40.00 FEET SOUTH OF, BY PERPENDICULAR MEASUREMENT, THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10, A DISTANCE OF 257.32 FEET;
2) THENCE N 72°13'56" E A DISTANCE OF 126.83 FEET, TO A POINT ON THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10;
THENCE ALONG SAID NORTH LINE OF THE WEST HALF OF SECTION 10, S 89°23'03" E, A DISTANCE OF 2267.15 FEET TO THE POINT OF BEGINNING;
CONTAINING AN AREA OF 62.298 ACRES MORE OR LESS.

Electronically Recorded RECEPTION#: 2018000097841,
12/6/2018 at 3:22 PM, 6 OF 6,
TD Pgs: 0 Stan Martin, Adams County, CO.

Homestead Heights II:

A PARCEL OF LAND LOCATED IN THE SOUTHWEST QUARTER OF SECTION 2, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH PRINCIPAL MERIDIAN,
COUNTY OF ADAMS, STATE OF COLORADO,

BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHWEST CORNER OF SAID SECTION 2; THENCE S89°12'04"E ALONG THE SOUTH LINE OF SAID SECTION 2, 30.00 FEET TO THE
TRUE POINT OF BEGINNING;

THENCE N00°11'20"E ALONG THE WEST LINE OF SAID PARCEL, AND PARALLEL TO THE WEST LINE OF SAID SOUTHWEST QUARTER OF SECTION 2, 1830.61 FEET TO THE NORTHWEST CORNER OF SAID PARCEL;
THENCE S89°12'34"E ALONG THE NORTH LINE OF SAID PARCEL, ALSO BEING THE SOUTH LINE OF ROCKING HORSE FARMS SUBDIVISION AND ITS DEDICATED RIGHT-OF-WAY DESCRIBED AT RECEPTION NO. C0611915 OF THE ADAMS COUNTY RECORDS, 2073.54 FEET TO A POINT ON THE WEST LINE OF SAID PARCEL, ALSO BEING ON THE EAST LINE OF SAID SUBDIVISION;
THENCE N00°07'27"E ALONG SAID LINE 855.37 FEET TO A POINT ON THE NORTH LINE OF SAID PARCEL, ALSO BEING ON THE SOUTH LINE OF SAID SUBDIVISION;
THENCE S89°48'36"E, ALONG SAID LINE 540.04 FEET TO THE NORTHEAST CORNER OF SAID PARCEL, ALSO BEING THE SOUTHEAST CORNER OF SAID SUBDIVISION;
THENCE S00°24'17"E 41.14 FEET TO THE CENTER QUARTER CORNER OF SAID SECTION 2;
THENCE S00°08'05"W ALONG THE NORTH/SOUTH CENTERLINE OF SAID SECTION 2 2650.90 FEET TO THE SOUTHEAST CORNER OF SAID PARCEL, ALSO BEING THE SOUTH QUARTER CORNER OF SAID SECTION 2;
THENCE N89°12'04"W ALONG THE SOUTH LINE OF SAID PARCEL, ALSO BEING THE SOUTH LINE OF THE SOUTHWEST QUARTER OF SAID SECTION 2, 2615.58 FEET TO THE
TRUE POINT OF BEGINNING;

SAID PARCEL CONTAINING 5,250,475.3 SQUARE FEET, OR 120.5 ACRES, MORE OR LESS.

After Recordation Return to:
WHITE BEAR ANKELE TANAKA & WALDRON
2154 East Commons Avenue, Suite 2000
Centennial, Colorado 80122

UTILITY EASEMENT AGREEMENT
(Greatrock North Water and Sanitation District)

For and in consideration of the sum of _____ Dollars ($___.00) and other good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, _____, whose address is _____ (the "Grantor"), hereby grants, bargains, sells and conveys to the GREATROCK NORTH WATER AND SANITATION DISTRICT, a quasi-municipal corporation and political subdivision of the State of Colorado, whose address is c/o Special District Management Services, Inc. 141 Union Boulevard, Suite 150, Lakewood, Colorado 80228 (the "District"), its successors and permitted assigns, a non-exclusive easement (the "Easement") to construct, reconstruct, repair, replace and/or remove certain water improvements and appurtenances thereto (the "Improvements"), in, to, through, over, under and across certain parcels of real property located in Adams County, Colorado, as more particularly described and shown in **Exhibit A**, attached hereto and incorporated herein by this reference (the "Premises"). Such Easement is granted by the Grantor and is accepted by the District pursuant to the following terms and conditions:

1. The District, its agents, successors and permitted assigns, shall have and exercise the right of ingress and egress in, to, through, over, under and across the Premises for any purpose necessary for the construction, reconstruction, operation, use, maintenance, repair, replacement and/or removal of the Improvements.

2. The Grantor, its successors and assigns, shall not construct or place any structure or building, street light, power pole, yard light, mailbox or sign, whether temporary or permanent, or plant any shrub, tree, woody plant, nursery stock, garden or other landscaping design feature on any part of the Premises, except with the prior written consent of the District. Any structure or building, street light, power pole, yard light, mailbox or sign, whether temporary or permanent, or any shrub, tree, woody plant, nursery stock, garden or other landscaping design feature of any kind situated on the Premises as of the date of this Easement or thereafter, except where the District has consented thereto, may be removed by and at the sole expense of the District in the District's exercise of its rights hereunder, without liability to the District therefor. Any structure or building, street, sidewalk, street light, power pole, yard light, mailbox or sign, whether temporary or permanent, or any shrub, tree, woody plant, nursery stock, garden or other landscaping design feature of any kind placed on the Premises by Grantor, its successors and assigns, subsequent to the date hereof without the District's consent may be removed by the District at the expense of Grantor, its successors or assigns, without liability to the District.

3. The District shall have the right to enter upon the Premises and to survey, construct, reconstruct, operate, use, maintain, repair, replace and remove the Improvements, and to remove objects interfering therewith, including but not limited to those items placed on the Premises under paragraph 2 hereof. In addition, the District shall have the right to use so much of the adjoining premises of the Grantor, its successors or assigns, during surveying, construction, reconstruction,

use, maintenance, repair, replacement and/or removal of the Improvements as may be reasonably required; provided, however, that such activities shall not interfere unreasonably with Grantor's, its successors' or assigns' use and enjoyment of such adjoining premises. The District and its permitted assignees and licensees shall repair any damage caused to any adjoining premises and the improvements thereon, and shall be liable for any injury to person or damage to property, to the extent arising out of the District's, its permitted assignee's or licensee's use of the Easement.

4. The District shall have and exercise the right of subjacent and lateral support to whatever extent is necessary for the operation and maintenance of the Improvements. It is specifically agreed between and among the parties that, except as provided in this Easement, the Grantor, its successors and assigns, shall not take any action which would impair the lateral or subjacent support for the Improvements. The Grantor, its successors and assigns, shall have and exercise the right of subjacent and lateral support to whatever extent is necessary for the operation and maintenance of any improvements on property adjoining the Premises. It is specifically agreed by and between the Grantor and the District that, except as provided in this Easement, the District shall not take any action which would impair the lateral or subjacent support for such improvements. This paragraph is not intended to prohibit the development of the private property located adjacent to the Premises.

5. It is expressly acknowledged and agreed that the District shall have the right and authority to assign the Easement to any appropriate local governmental entity or to any public utility provider, including but not limited to all rights to use, and all obligations associated with, the Easement as are granted to and assumed by the District herein, subject to such assignee assuming the obligations set forth herein. The District shall have the right and authority to grant temporary construction easements to any appropriate local governmental entity or public utility provider for purposes of construction, reconstruction, operation, use, maintenance, repair, replacement and/or removal of the Improvements, subject to all of the terms and conditions of this Easement.

6. The District agrees that at such time and in the event that the Improvements or Easement described herein are abandoned by the District and any permitted assignee, the Easement will terminate automatically and the real property interest represented by the Easement will revert to the Grantor, its heirs, successors and/or assigns.

7. The Grantor covenants and agrees with the District that the Grantor has full power and lawful authority to grant, bargain, sell and convey the Easement and that the Premises are free and clear from all former and other grants, bargains, sales, liens, taxes, assessments, encumbrances and restrictions of whatever kind or nature, except matters of record. The Grantor further promises and agrees to warrant and forever defend the District in the exercise of the District's rights hereunder against any defect in the Grantor's title to the Premises and the Grantor's right to make the grant herein described, except matters of record.

8. Each and every one of the benefits and burdens of this Easement shall inure to and be binding upon the respective legal representatives, administrators, successors and permitted assigns of the Grantor and the District.

9. The Grantor, its successors and assigns, reserve the right to grant further easement interests in the Premises to other grantees so long as such interests and uses are not inconsistent with,

or unreasonably interfere with, the use of the Premises and benefits of this Easement by the District, its successors and permitted assigns, as described herein.

10. The rights and responsibilities set forth in this Easement are intended to be covenants on the Premises and are to run with the land.

11. This Easement shall be recorded in the real property records of Adams County.

12. This Easement may be executed in several counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument.

[Remainder of page intentionally left blank].

IN WITNESS WHEREOF, the parties have executed this Easement this ____ day of _____ 20__.

GRANTOR:

_____

STATE OF COLORADO)
) ***ss.***
COUNTY OF)

Subscribed and sworn to before me on this _____ day of _____ 20__, by _____.

[SEAL]

_____
Notary Public

My commission expires _____

DISTRICT:
GREATROCK NORTH WATER AND SANITATION DISTRICT

_____
President

_____
_____

STATE OF COLORADO)
) ***ss.***
COUNTY OF ADAMS)

Subscribed and sworn to before me on this _____ day of _____ 20__, by _____ as President of the Greatrock North Water and Sanitation District, a quasi-municipal corporation and political subdivision of the State of Colorado.

[SEAL]

_____
Notary Public

My commission expires _____

EXHIBIT A

The Premises

MEMORANDUM

TO: Lisa Johnson, District Manager, Greatrock North Water and Sanitation District

FROM: Brad Simons, MMI Water Engineers, LLC

RE: Preliminary Plat Review Comments for Ridgeview Estates (PLT2018-00044)

DATE: January 23, 2019

CC: N/A

I have reviewed the submittal for the above referenced case received by MMI Water Engineers, LLC on January 7, 2019 and offer the following comments for consideration in the Greatrock North Water and Sanitation District's response to the Adams County Community & Economic Development Department:

1. An Inclusion Agreement between Ridgeview Estates LLC (Owner) and Greatrock North Water and Sanitation District (District) was entered into the 24th day of July 2008. Said Inclusion Agreement indicates, among other things:
    a. The Owner and the property which the Owner intends to develop shall be bound by and subject to the District's Rules and Regulations (para. 2.).
    b. The Owner shall convey to the District all water and water rights, including, but not limited to, tributary, and nontributary and not nontributary water rights, ditches and ditch rights, wells and well rights, reservoirs and reservoir rights, whether decreed or undecreed, permitted or unpermitted, underlying, associated with, or appurtenant to the property and, to the extent applicable, adjacent right-of-way, including all water rights associated with the 62.3 acre subdivision pursuant to a Special Warranty Deed. The process for adjudicating the water conveyed shall begin one hundred twenty (120) days after recordation of the Final Plat for the Ridgeview Estates subdivision. The adjudication process may begin prior to that date if mutually agreed upon by Owner and District (para. 6.).
    c. Upon inclusion into the District, the District will provide water for twenty-one (21) approximately 2.5 acre lots in the Ridgeview Estates subdivision to satisfy in-home uses, irrigated areas not-to-exceed four thousand (4,000) square feet per lot, and livestock use (horses) not-to-exceed two (2) horses per acre, all in accordance with the District's Rules and Regulations (para. 6.).

   d. The Owner shall be responsible for the construction of a single eight inch (8") looped water line in accordance with District specifications as necessary to serve the property. At the time of the Inclusion Agreement, the water improvements had not yet been identified but the Inclusion Agreement indicates the water improvements will be identified jointly by the District and the Owner upon receipt of all information (para. 8).
   e. The Owner shall grant and convey to the District, by plat dedication and/or separate agreement, any and all easements and rights-of-way within and without the property required by the District to serve the property, including an easement for one 40' x 100' well site on the property located on the east end of Tract A on the Final Plat for Ridgeview Estates (para. 13.a.).
2. The Owner has conveyed the water rights referenced above to the District, but the adjudication process referenced above has not been initiated by the District.
3. Ultimately, the District may decide to seek approval to withdraw the Ridgeview Estates Denver Basin groundwater as part of the District's wellfield located off the Ridgeview Estates parcel, but the District should obtain the 40' x 100' well site easement so it is not precluded from drilling a Denver Basin well on Tract A if it deems the well necessary in the future.
4. The other easements and rights-of-way referenced in para. 13. of the Inclusion Agreement appear to be addressed on the preliminary plat attached to the Request for Comments.
5. On January 22, 2019, MMI Water Engineers, LLC received "Final Construction Plans", dated December 3, 2018, from David Moore, of Alliance Consulting. The "Final Construction Plans" have not been reviewed or approved by the District as of the date of this memorandum regarding Preliminary Plat Review Comments for Ridgeview Estates (PLT2018-00044).

Should you have any comments or questions, please contact me at 720-234-8398.

MEMORANDUM

TO: Layla Bajelan, Adams County Community and Economic Development

FROM: Brad Simons, Greatrock North Water and Sanitation District

RE: Ridgeview Estates Filing No. 1, Final Plat-3rd Submittal (PLT2019-00026)

DATE: March 16, 2020

CC: David Solin, District Manager, and Jennifer Tanaka, District General Counsel

I have reviewed 1) the submittal for the above referenced case received by MMI Water Engineers, LLC on February 28, 2020, and 2) the updated materials posted to the County's website on March 9, 2020. On behalf of the Greatrock North Water and Sanitation District, I offer the following comments for consideration:

1. The "LIENHOLDER CERTIFICATE" on Sheet 1 or 2 for the final plat for "Ridgeview Estates – Filing No. 1" still indicates the District "consent(s) to the dedication and easements shown on this plat and release(s) the same from the encumbrance recorded at Reception No. 2018000097841 of the records of the Adams County Clear and Recorder". A copy of the Statement of Lien is included for reference. The District will only execute the "LIENHOLDER CERTIFICATE" if the applicant pays the unpaid system development fees. Otherwise, said system development fees are due and owed on each single-family residential equivalent unit within five (5) business days of the issuance of a building permit by Adams County for that specific single-family residential equivalent unit. On March 10, 2020, the District met with the applicant to discuss the "LIENHOLDER CERTIFICATE" statement. On March 11, 2020, the applicants engineer, Patrick Domagall, indicated he had removed the statement and republished the plat file. A copy of the revised plat is attached to this memorandum for reference.
2. The cover sheet for "Ridgeview Estates – Filing No. 1" indicates a Homeowner's Association will be created and will have a number of responsibilities:

   Note 6: The Homeowner's Association shall be created and in place prior to recording of this plat.

   Note 13: Drainage easements as shown on the plat are dedicated to and will be maintained by the Homeowner's Association for the purpose of providing storm water drainage throughout the subdivision and for the maintenance thereof.

Note 17: Equestrian easements are hereby dedicated to the Homeowner's Association for the purpose of maintaining said easement areas as an equestrian trail used by the Association members and guests. No fencing is allowed within the equestrian easements except the exterior perimeter fence, on the boundary of Ridgeview Estates, provided and maintained by the Homeowner's Association.
Note 18: Tract A is for future water well establishment by Great Rock North Water and Sanitation District and shall be owned and maintained by the Homeowner's Association. It is the District's preference to own and maintain Tract A as it is a potential site for future water well(s) to serve the District's public water system.
Note 19: Tract B for the detention pond shall be owned and maintained by the Homeowner's Association.
Note 22: Kallsen 110 Gas Well motorized access easement to be maintained by the HOA.

The District has previously communicated concerns to Adams County regarding the enforcement of plat conditions (i.e. Notes) in the event a Homeowner's Association dissolves. The County has indicated it does not regulate Homeowner's Associations and that if an Association dissolves, the responsibilities revert to the individual homeowners. I previously provided public comment regarding Homeowner's Associations at a Commissioner meeting on January 14, 2020 and have reached out to Commissioner O'Dorisio as a follow-up regarding Homeowner's Associations conceptualized during the platting process.

3. Note 20 on Sheet 1 or 2 for "Ridgeview Estates – Filing No. 1" indicates the Monaghan Mile Road access to the south of this subdivision shall be for emergency vehicles only and that an automatic gate shall be installed per the Greater Brighton Fire Protection District standards for restricted access gates. The future Monaghan Mile Road access road should extend to the end of Deer Park Street.
4. The District requires separately recorded instruments (i.e. Utility Easement Agreements) for the dedication of non-exclusive utility easements for the construction, reconstruction, repair, replacement, and/or removal of water improvements and appurtenance thereto across Lot 1, Lot 6, and Lot 7. A copy of the District's form of Utility Easement Agreement is attached for reference and was e-mailed to the applicant on March 11, 2020.
5. The applicant needs to confirm the "50' Equestrian Easement" in the Greatrock North subdivision as shown on the "Master Utility Plan" allows for the construction of water improvements to Tract A of the Greatrock North subdivision.

Should you have any comments or questions, please contact me at 720-234-8398.

November 1, 2019

Layla Bajelan
Adams County Community and Economic Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601

RE: Ridgeview Estates, PLT2019-00026
TCHD Case No. 5927

Dear Ms. Bajelan,

Thank you for the opportunity to review and comment on the Preliminary Plat for a major subdivision to create 21 lots, approximately 2.5 acres in size, located southeast of Monaghan Road and east of 160th Avenue. Tri-County Health Department (TCHD) staff has reviewed the application for compliance with applicable environmental and public health regulations and principles of healthy community design. After reviewing the application, TCHD has the following comments.

Onsite Wastewater Treatment Systems (OWTS) - Proposed Subdivision
Proper wastewater management promotes effective and responsible water use, protects potable water from contaminants, and provides appropriate collection, treatment, and disposal of waste, which protects public health and the environment. TCHD has no objection to the proposed subdivision being served by Onsite Wastewater Treatment Systems (OWTS), provided the systems are permitted, installed, and operated in compliance with our current OWTS regulation

Oil and Gas
Adams County and the Colorado Oil and Gas Conservation Commission (COGCC) regulate the setback requirements of oil and gas wells and production facilities in order to eliminate, minimize, or mitigate potential adverse impacts to public health. Adams County requires a setback of 1000 feet from a new well to a residential property line. An existing oil and gas well is located within the subject property. TCHD recommends the applicant adhere to the setbacks outlined above, at a minimum.

Please feel free to contact me at 720-200-1575 or kboyer@tchd.org if you have any questions on TCHD's comments.

Sincerely,

Kathy Boyer, REHS
Land Use and Built Environment Specialist III

cc: Sheila Lynch, Monte Deatrich, TCHD

Hello,

Thank you for inviting United Power, Inc. to review and comment on the case referral for Ridgeview Estates Filing No. I, Final Plat-2nd submittal).

We will require the following for dry utilities:

- **General** - 8’ to 10’ wide utility easements along rear of all lots, sides of lots abutting roads, and across tracts. This allows us to install electric facilities in a continuous manner for our loop feed which provides reliability.
- **Tracts/Open Space/Parks** - 8’ to 10’ wide utility easements along perimeter of tracts, along perimeter of tracts abutting roads, and through tracts between lots. United Power prefers blanket utility use within tracts be dedicated as this gives us the opportunity to set above ground equipment, if needed and coordinated with the developer.
- **Streetlights** - If streetlight locations are known, we need a 5' wide utility easement along one side of the lot closest to the streetlight location. No permanent structures are acceptable within the utility easement; such as, window wells, wing walls, retaining walls, etc. All streetlight locations must be approved and signed off by the city/town, etc.

United Power would like to work with the developer early in the construction process on getting an electric design prepared so that we can request any additional easements needed and can be dedicated on the plat rather than obtaining via separate document. The developer can visit https://www.unitedpower.com/construction and submit an application along with CAD data.

We look forward to safely and efficiently providing reliable electric power and outstanding service to future members.

Thank you,

Samantha Riblett
United Power, Inc
Right of Way Administrative Assistant
Main 303-659-0551|D 303-637-1324

Right of Way & Permits

1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571. 3284
donna.l.george@xcelenergy.com

January 16, 2020

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Layla Bajelan

Re: Ridgeview Estates Filing No. 1 - 2nd referral, Case # PLT2019-00026

Public Service Company of Colorado's (PSCo) Right of Way & Permits Referral Desk acknowledges the comment response for **Ridgeview Estates Filing No. 1** and has no further concerns at this time.

The property owner/developer/contractor is reminded to to continue working with the Designer assigned to the project for approval of design details. Additional easements may need to be acquired by separate document for new facilities.

Donna George
Right of Way and Permits
Public Service Company of Colorado dba Xcel Energy
Office: 303-571-3306 – Email: donna.l.george@xcelenergy.com

Right of Way & Permits

1123 West 3rd Avenue
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donna.l.george@xcelenergy.com

November 2, 2019

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Layla Bajelan

Re: Ridgeview Estates Phase I, Case # PLT2019-00026

Public Service Company of Colorado's (PSCo) Right of Way and Permits Referral Desk has reviewed the plat for **Ridgeview Estates Phase One**. As always, thank you for the opportunity to take part in the review process. To ensure that adequate utility easements are available within this development and per state statutes, PSCo requests that the front lot 14-foot utility and drainage easements continue within Tracts A and B abutting the East 159th Avenue right-of-way, for continuity and connection of the utilities.

Public Service Company also requests that the following language or plat note is placed on the preliminary and final plats for the subdivision:

> *Utility easements are dedicated to Adams County for the benefit of the applicable utility providers for the installation, maintenance, and replacement of electric, gas, television, cable, and telecommunications facilities (Dry Utilities). Utility easements shall also be granted within any access easements and private streets in the subdivision. Permanent structures, improvements, objects, buildings, wells, and other objects that may interfere with the utility facilities or use thereof (Interfering Objects) shall not be permitted within said utility easements and the utility providers, as grantees, may remove any Interfering Objects at no cost to such grantees, including, without limitation, vegetation. Public Service Company of Colorado (PSCo) and its successors reserve the right to require additional easements and to require the property owner to grant PSCo an easement on its standard form.*

Public Service Company also requests that all utility easements are depicted graphically on the preliminary and final plats. While these easements should accommodate the majority of utilities to be installed in the subdivision, some additional easements may be required as planning and building progresses.

The property owner/developer/contractor must complete the application process for any new natural gas service via xcelenergy.com/InstallAndConnect. It is then the responsibility of the

November 4, 2019

Layla Bajelan
Long Range Planner I
Adams County Community Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601-8218

RE: Ridgeview Estates Phase I, Final Plat

Dear Ms. Bajelan,

I am a resident of Greatrock North, which shares a border with the planned development. I attended the public meeting held on this development. My home is directly across from the stop sign on 160th Avenue (Great Rock Way at the end) at the southwest entrance to our neighborhood. I do not object to the new development and am glad it is 2.5 acre lots and will include an equestrian trail like our neighborhood has, since it borders our equestrian trail. I would like to see the trail made a requirement of the plat approval.

My primary concern is traffic impact through Greatrock North to reach Hayesmount Road. We already have a great number of vehicles that are cutting through our residential neighborhood from the new housing developments to the east. If people are working, shopping, etc. to destinations along 160th Avenue (Bridge Street) in Brighton, they cut through Greatrock North – primarily looping around on East 160th Place to exit our neighborhood on East 162nd Avenue to Hayesmount Road. Here are my traffic concerns:

- The Greatrock North Equestrian trail crosses 160th Avenue (see red trail marking on aerial, next page). When on horseback, we have to travel along 160th Avenue (Great Rock Way) to get to the trail on the other side of the road. The speed limit drops to 25 mph, but this is where speeders are such a danger. Their visibility coming along the curve as they approach the first houses is limited. Much more obvious speed limit traffic control devices are needed here. A flashing light on the speed sign (ideally a sign that shows the driver their speed), hatch marks on the roadway delineating the horse crossing, and signage that shows it is a horse crossing are needed.

- Horse owners in Greatrock North whose homes do not back to the equestrian trail have to access the trail by traveling the roads in the development to reach a signed, trail access point or access it via 160th Avenue. There are also bicyclists, dog walkers and other pedestrians, and kids playing along the roads in the neighborhood, which has no sidewalks, at all hours. A traffic study that shows how much of the traffic is cutting through Greatrock North to Hayesmount is needed in both directions. There are peak commute times, but we also get such traffic on weekends and evenings on the weekends. We appreciate that these roads were recently chip-sealed again. The traffic study would show where speed control devices would be useful. Rounded speed bumps have not been desired in this neighborhood because people hauling horse trailers do not like them. But the newer style wide, flat type might be an option.
- Alliance Development's final plat shows Monaghan Road continuing on the north side of 160th Avenue, indicating it is not constructed. At the location shows on the plat, that road would be on Greatrock North's horse trail. I am not sure if that is just how it was shown by the surveying company that prepared the plat or if there are plans to develop a road in that location. Could you please let me know?

Because my home faces the stop sign, I observe many vehicles that arrive there and are lost. Every day there are vehicles pulling over and trying to look on their phones to figure out where they are. I have had people come to my door for directions back to Brighton or to get to Bromley Lane. While it is not related to the final plat under consideration, I wanted to suggest that your department take a look at signage on

160th leaving Brighton eastbound that could help these drivers not come all the way east past Harvest Road.

Lost and speeding drivers have twice impacted my property by running off the road. A driver drove straight across at the stop sign one night in June last year, went across the ditch and tried to turn around to go back but went into the ditch further west over huge rocks, getting stuck in the culvert and taking out the Comcast pedestal. He was apparently unconscious and bleeding until daylight. In May this year, a driver became airborne off of 160th Place west bound, and her car landed partially on my concrete driveway and partially on my culvert pipes. She was trying to get to Brighton and I was told she said she was lost. Law enforcement (CHP and Adams County Sheriff Deputies), Brighton Fire Rescue and Platte Valley Ambulance responded. Luckily neither driver from these two incidents appeared injured, although I believe both vehicles were totaled. These accidents document the need for better traffic signage for our neighborhood.

Thank you for taking my comments into consideration.

Nancy Ross
28545 East 160th Place
Brighton CO 80603
720-291-7734 (cell)

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Request for Comments

Case Name: Ridgeview Estates Phase I, Final Plat

Case Number: PLT2019-00026

October 15, 2019

The Adams County Planning Commission is requesting comments on the following application:

Ridgeview Estates Phase I, Final Plat. The Assessor's Parcel Number is 0156710200001.

Applicant Information: Alliance Development Services
David Moore P.E.
16415 W 85TH LN UNIT B
ARVADA, CO 80007

Please forward any written comments on this application to the Community and Economic Development Department at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216 or call (720) 523-6800 by 11/04/2019 in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to LBajelan@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional colored maps can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Layla Bajelan

Layla Bajelan, Long Range Planner I
Case Manager

Referral Listing
Case Number PLT2019-00026
Ridgeview Estates, Filing 1

Agency	Contact Information
Adams County Attorney's Office	Christine Fitch 4430 S Adams County Pkwy Brighton CO 80601 720-523-6352 CFitch@adcogov.org
Adams County CEDD Addressing	Mark Alessi PLN 720.523.6837 malessi@adcogov.org
Adams County CEDD Development Services Engineer	Devt. Services Engineering 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6800
Adams County CEDD Right-of-Way	Mark Alessi 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6837 malessi@adcogov.org
Adams County Community & Economic Development Department	Gina Maldonado 4430 S. Adams County Pkwy Brighton CO 80601 720-523-6823 gmaldonado@adcogov.org
Adams County Community Safety & Wellbeing, Neighborhood Services	Gail Moon 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6856 gmoon@adcogov.org
Adams County Construction Inspection	Gordon .Stevens 4430 S. Adams County Pkwy Brighton CO 80601 720-523-6965 gstevens@adcogov.org
Adams County Development Services - Building	Justin Blair 4430 S Adams County Pkwy Brighton CO 80601 720-523-6825 JBlair@adcogov.org

Agency	Contact Information
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Adams County Parks and Open Space Department	Marc Pedrucci 303-637-8014 mpedrucci@adcogov.org
Adams County Sheriff's Office	- - 303-655-3283 CommunityConnections@adcogov.org
Adams County Sheriff's Office	Rick Reigenborn (303) 654-1850 rreigenborn@adcogov.org
Adams County Treasurer	Lisa Culpepper 4430 S. Adams County Pkwy. Brighton CO 80601 720.523.6166 lculpepper@adcogov.org
BRIGHTON FIRE DISTRICT	Whitney Even 500 South 4th Avenue 3rd Floor BRIGHTON CO 80601 (303) 659-4101 planreviews@brightonfire.org
BRIGHTON SCHOOL DISTRICT 27J	Kerrie Monti 1850 EGBERT STREET SUITE 140, BOX 6 BRIGHTON CO 80601 303-655-2984 kmonti@sd27j.net
Century Link, Inc	Brandyn Wiedreich 5325 Zuni St, Rm 728 Denver CO 80221 720-578-3724 720-245-0029 brandyn.wiedrich@centurylink.com
COLO DIV OF WATER RESOURCES	Joanna Williams OFFICE OF STATE ENGINEER 1313 SHERMAN ST., ROOM 818 DENVER CO 80203 303-866-3581 joanna.williams@state.co.us
COLORADO DIVISION OF WILDLIFE	Matt Martinez 6060 BROADWAY DENVER CO 80216-1000 303-291-7526 matt.martinez@state.co.us
COLORADO DIVISION OF WILDLIFE	Serena Rocksund 6060 BROADWAY DENVER CO 80216 3039471798 serena.rocksund@state.co.us

Agency	Contact Information
COLORADO GEOLOGICAL SURVEY	Jill Carlson 1500 Illinois Street Golden CO 80401 303-384-2643 303-384-2655 CGS_LUR@mines.edu
Colorado Geological Survey: CGS_LUR@mines.edu	Jill Carlson Mail CHECK to Jill Carlson 303-384-2643 303-384-2655 CGS_LUR@mines.edu
COMCAST	JOE LOWE 8490 N UMITILLA ST FEDERAL HEIGHTS CO 80260 303-603-5039 thomas_lowe@cable.comcast.com
GREATROCK NORTH HOA	CYRENA DRUSE 28650 E 160TH PL BRIGHTON CO 80603 720-233-8817
Greatrock Water District	LISA JOHNSON 141 Union Blvd., #150 Lakewood CO 80228 720-552-3696 lisa.johnson@claconnect.com
NS - Code Compliance	Gail Moon gmoon@adcogov.org 720.523.6833 gmoon@adcogov.org
REGIONAL TRANSPORTATION DIST.	Engineering RTD 1560 BROADWAY SUITE 700 DENVER CO 80202 303-299-2439 engineering@rtd-denver.com
United Power	- - 303-659-0551 platreferral@unitedpower.com
United States Postal Service	Jason Eddleman 303-853-6025 Jason.G.Eddleman@usps.gov
United States Postal Service	Arlene Vickrey 303-853-6644 Arlene.A.Vickrey@usps.gov
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com

GREATROCK NORTH HOMEOWNERS ASSOCIATION
141 UNION BLVD STE 150
LAKEWOOD CO 80228-1898

JACKSON JUDITH GAIL
2308 LOWER RIVER RD
GRANTS PASS OR 97526-9010

KNAFEL DOUGLAS
10 PINE STREET
STOCKBRIDGE MA 01262

MUNOZ FAMILY PARTNERS LTD
PO BOX 264
BOYD TX 76023-0264

PADE ELIZABETH FORD MITCHELL
360 BALSAM ST
LAKEWOOD CO 80226-1339

RIDGEVIEW ESTATES LLC
8155 MOORE ST
ARVADA CO 80005-2025

15711 GADSDEN DR LLC
OR CURRENT RESIDENT
15711 GADSDEN DR
BRIGHTON CO 80603-8866

ALLEN MICHAEL E SR AND
ALLEN JOANN M
OR CURRENT RESIDENT
15682 GADSDEN DR
BRIGHTON CO 80603

AVERKOV PAVEL AND AVERKOV ANTON AND
AVERKOVA LYUBOV
OR CURRENT RESIDENT
15895 GADSDEN DR
BRIGHTON CO 80603-8865

BEAVER KENNETH D AND
BEAVER BRENDA S
OR CURRENT RESIDENT
15915 GADSDEN DR
BRIGHTON CO 80603

BEZRUKAVYY VITALIY N AND
BEZRUKAVAYA LARISA L
OR CURRENT RESIDENT
28930 E 160TH PL
BRIGHTON CO 80603-8446

BOEN HARLAN E AND
BOEN SHARRELL B
OR CURRENT RESIDENT
15722 GADSDEN DR
BRIGHTON CO 80603

BRIENZA EUGENE J II AND
BRIENZA GAIL P
OR CURRENT RESIDENT
28560 E 162ND CT
BRIGHTON CO 80603-8440

CABRIALES CHRISTOPHER L
OR CURRENT RESIDENT
16120 ELECTRA ST
BRIGHTON CO 80603-8420

CAMPBELL ROBERT M AND
CAMPBELL CHRISTINE A
OR CURRENT RESIDENT
28355 E 160TH AVENUE
BRIGHTON CO 80603

CHAMBERS WILLIAM C
OR CURRENT RESIDENT
28700 E 160TH PL
BRIGHTON CO 80603-8445

CHRISMAN BRENDA
OR CURRENT RESIDENT
15835 GADSDEN DR
BRIGHTON CO 80603-8865

DEVOE KEITH W AND
DEVOE LORI JO POMPIA
OR CURRENT RESIDENT
28880 E 160TH PLACE
BRIGHTON CO 80603

DRUSE RYAN LAWRENCE
OR CURRENT RESIDENT
28650 E 160TH PL
BRIGHTON CO 80603-8445

ESPINOZA RIGOBERTO AND
ESPINOZA BLANDINA
OR CURRENT RESIDENT
15995 GADSDEN DRIVE
BRIGHTON CO 80603

FALCO CHRISTINA MARIE AND
FURROW TIFFANY
OR CURRENT RESIDENT
28575 E 160TH PL
BRIGHTON CO 80603-8449

FIELDS GEORGE L AND
FIELDS ANITA J
OR CURRENT RESIDENT
28400 E 160TH AVE
BRIGHTON CO 80603-8442

FLORES ALBERT G AND
BLEA-FLORES JENA N
OR CURRENT RESIDENT
16135 BENTLY ST
BRIGHTON CO 80603-8439

FREESE TERRY L AND
BOSCIA-FREESE GWENDOLYN R
OR CURRENT RESIDENT
28525 E 160TH AVE
BRIGHTON CO 80603-8444

GAGNA LEE A AND
GAGNA TERESA
OR CURRENT RESIDENT
28615 E 160TH PLACE
BRIGHTON CO 80603

GAMBOA RAYMOND V AND
GAMBOA LISA D
OR CURRENT RESIDENT
29449 GADSDEN DR
BRIGHTON CO 80603

GILLASPIE BYRON K AND
GILLASPIE CYNTHIA
OR CURRENT RESIDENT
28300 E 160TH AVE
BRIGHTON CO 80603-8441

GREENBERG WENDY E AND
MOORE BETH A
OR CURRENT RESIDENT
15615 GADSDEN DR
BRIGHTON CO 80603

HAMILTON ANDREW C AND SUSAN L
OR CURRENT RESIDENT
29145 E 160TH CT
BRIGHTON CO 80603

HAMILTON PATRICK M AND
HAMILTON CHRISTINE L
OR CURRENT RESIDENT
16195 DEL RAY CT
BRIGHTON CO 80603-8431

HERNBLOOM DAVID M AND
HERNBLOOM MARYLU
OR CURRENT RESIDENT
28350 E 160TH AVENUE
BRIGHTON CO 80603

HOUSTON HARVEY H JR AND
HOUSTON MARY E
OR CURRENT RESIDENT
28820 E 160TH PLACE
BRIGHTON CO 80603

HRUBY ROGER R AND
HRUBY ELIZABETH A
OR CURRENT RESIDENT
15735 GADSDEN DR
BRIGHTON CO 80603-8866

HUNT DWAYNE D
OR CURRENT RESIDENT
27705 E 160TH AVE
BRIGHTON CO 80603-8402

JANSSEN IVAN L AND
JANSSEN KAREN K
OR CURRENT RESIDENT
15675 GADSDEN DR
BRIGHTON CO 80603

KAWANO STEVEN R AND
KAWANO DANIELLE L
OR CURRENT RESIDENT
28925 E 160TH PL
BRIGHTON CO 80603-8451

KEEVER JOHN E AND
KEEVER VALERIE L
OR CURRENT RESIDENT
15742 GADSDEN DR
BRIGHTON CO 80603-8858

LACASSE CHRISTOPHER AND
OZAWA KATHRINE
OR CURRENT RESIDENT
15782 GADSDEN DR
BRIGHTON CO 80603-8858

LANGEBERG MARK F AND
LANGEBERG AMY S
OR CURRENT RESIDENT
28745 E 160TH PLACE
BRIGHTON CO 80603

LANGHORST RUSSELL L AND
LANGHORST BARBARA A
OR CURRENT RESIDENT
28675 E 160TH PLACE
BRIGHTON CO 80603

MADDOX HENRY C AND
MADDOX SHEILA H
OR CURRENT RESIDENT
29000 E 160TH PL
BRIGHTON CO 80603

MAPES JAMES GRANT AND
MOHARI NIVEDITA
OR CURRENT RESIDENT
29400 GADSDEN DR
BRIGHTON CO 80603-8843

MAUL BRADLEY R
OR CURRENT RESIDENT
29399 GADSDEN DR
BRIGHTON CO 80603-8863

MC COLLUM MICHELLE AND
JAUDON MIKE
OR CURRENT RESIDENT
15882 GADSDEN DR
BRIGHTON CO 80603

MC ENDREE STEVEN R AND
MC ENDREE LOANNA L
OR CURRENT RESIDENT
15775 GADSDEN DR
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MC GRADY MICHAEL P AND
MC GRADY DIONNE L
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28815 E 160TH PL
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MITCHELL MARJORIE M AND
MITCHELL RITA C
OR CURRENT RESIDENT
16125 ELECTRA ST
BRIGHTON CO 80603-8418

NASON GEORGE W AND
NASON ROBYN G
OR CURRENT RESIDENT
15802 GADSDEN DR
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NEFF DAVID R AND
NEFF LINDA A
OR CURRENT RESIDENT
28580 E 160TH PLACE
BRIGHTON CO 80603-8445

NEWHALL CHANDLER C AND
NEWHALL AMY R
OR CURRENT RESIDENT
15700 MONAGHAN RD
BRIGHTON CO 80603

ONKEN WILLIAM W AND
ONKEN SHANNON
OR CURRENT RESIDENT
15655 GADSDEN DR
BRIGHTON CO 80603

PENNETTA RICKY L AND ANREA D
OR CURRENT RESIDENT
29389 GADSDEN DR
BRIGHTON CO 80603

PLUMISTO GENE N AND
PLUMISTO DEBORAH L
OR CURRENT RESIDENT
28875 E 160TH PL
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POLLIARD JEFFREY L AND
POLLIARD CHRISTINE M
OR CURRENT RESIDENT
28205 E 160TH AVENUE
BRIGHTON CO 80603

PRICE ROBERT AND
GEESA CAMMIE
OR CURRENT RESIDENT
28380 E 162ND CT
BRIGHTON CO 80603-8447

REDEKOP TIMOTHY E AND
REDEKOP LAURA A
OR CURRENT RESIDENT
15702 GADSDEN DR
BRIGHTON CO 80603-8858

RIEBSCHLAGER LAURENCE ROBERT AND
RIEBSCHLAGER LINNEA LEA
OR CURRENT RESIDENT
15762 GADSDEN DR
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ROSS NANCY
OR CURRENT RESIDENT
28545 E 160TH PL
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SCAGGIARI CHRIS A AND
SCAGGIARI SHERRY
OR CURRENT RESIDENT
29430 GADSDEN DR
BRIGHTON CO 80603-8843

SHELL KAREN A AND
SHELL THOMAS D
OR CURRENT RESIDENT
28540 E 162ND CT
BRIGHTON CO 80603-8440

SIMPSON STEVEN AND
SIMPSON AMBER
OR CURRENT RESIDENT
16125 BENTLY ST
BRIGHTON CO 80603-8439

SMITH RICHARD D AND
SMITH LISA C
OR CURRENT RESIDENT
28500 E 160TH AVE
BRIGHTON CO 80603

SMITS HARRY L AND
SMITS KARI L
OR CURRENT RESIDENT
29070 E 160TH CT
BRIGHTON CO 80603-8421

SOBCZYK CHRISTOPHER AND
SOBCZYK CHRISTEN
OR CURRENT RESIDENT
15902 GADSDEN DR
BRIGHTON CO 80603-8860

SPEARS GARY L AND MARYBETH
OR CURRENT RESIDENT
27670 E 160TH AVE
BRIGHTON CO 80603

STARNS ROLF A AND
STARNS RONA K
OR CURRENT RESIDENT
28435 E 160TH AVENUE
BRIGHTON CO 80603

STEWART TROY AND
STEWART ROXANE
OR CURRENT RESIDENT
28285 E 160TH AVE
BRIGHTON CO 80603-8444

STUART ROBERT W
STUART CHERYL K
OR CURRENT RESIDENT
28440 E 162ND CT
BRIGHTON CO 80603-8447

SVYATETSKIY PETR AND
SVYATETSKAYA LYUBOV
OR CURRENT RESIDENT
29005 E 160TH PL
BRIGHTON CO 80603-8429

SZYDLEK EDWIN P AND
SZYDLEK CYNTHIA A
OR CURRENT RESIDENT
28760 E 160TH PLACE
BRIGHTON CO 80603

TAYLOR JEFFREY
TAYLOR KRISTY
OR CURRENT RESIDENT
28610 E 160TH PL
BRIGHTON CO 80603-8445

THOLLOT TROY M AND
THOLLOT JOY I
OR CURRENT RESIDENT
16185 DEL RAY COURT
BRIGHTON CO 80603

THORNTON RANDALL J AND
THORNTON DEBRA J
OR CURRENT RESIDENT
15755 GADSDEN DR
BRIGHTON CO 80603-8866

VANDERMEER JENNIFER A
OR CURRENT RESIDENT
29200 E 160TH CT
BRIGHTON CO 80603-8422

VAZQUEZ DANIEL AND
HERNANDEZ ADAN VAZQUEZ
OR CURRENT RESIDENT
16190 DEL RAY CT
BRIGHTON CO 80603-8431

ZENTENO LUIS R AND
HOPPE-ZENTENO NICOLE M
OR CURRENT RESIDENT
15695 GADSDEN DR
BRIGHTON CO 80603

CURRENT RESIDENT
27905 E 160TH AVE
BRIGHTON CO 80603-8400

CURRENT RESIDENT
27910 E 160TH AVE
BRIGHTON CO 80603-8401

CURRENT RESIDENT
29150 E 160TH CT
BRIGHTON CO 80603-8421

CURRENT RESIDENT
15787 MONAGHAN RD
BRIGHTON CO 80603-8813

CURRENT RESIDENT
15795 GADSDEN DR
BRIGHTON CO 80603-8866

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Request for a Major Subdivision Final Plat to create three lots from three existing parcels.
FROM: Jill Jennings Golich, Director
AGENCY/DEPARTMENT: Community and Economic Development Department
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves PLT2020-00018; JRJK Dream Acres Final Plat with the recommended Findings-of Facts, Conditions, and Notes.

BACKGROUND:

On February 25, 2020, the Board of County Commissioners approved a major subdivision preliminary plat and rezone from A-3 to A-1 for JRJK Dream Acres to create three lots from three existing parcels.

The applicants, James and Kathleen Hill, are requesting a major subdivision final plat. The plat request encompasses three existing parcels in the vicinity of 13830 and 13850 Franklin Street. The subdivision application will allow for the two existing property owners to incorporate acreage from the larger parcel into their established lots. There would be one A-1 lot established with this request, however the total number of parcels would remain the same. This newly created lot could be developed with one single-family dwelling.

As proposed, the majority of the land would be incorporated into the applicant's parcel (13830 Franklin Street), which would be Lot 1 and consist of 27.6 acres. In addition, the property to the north would also incorporate a portion of the land from the 35-acre parcel, which would become Lot 2 and consist of 7.3 acres. There would be a third lot, Lot 3, that would be created and consist of 5.4 acres. As shown on the plat, easements and setback buffers are in place for the existing oil and gas wells on the proposed 5.4-acre parcel.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community and Economic Development
County Attorney

ATTACHED DOCUMENTS:

Resolution Approving Application in Case #PLT2020-00018; JRJK Dream Acres Final Plat
Board of County Commissioners Packet

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING APPLICATION IN CASE # PLT2020-00018; JRJK DREAM ACRES FINAL PLAT

Resolution 2020-###

WHEREAS, this case involves a request for a Major Subdivision Final Plat to create three lots from the existing three parcels.

LOCATION: 13830 and 13850 Franklin Street

LEGAL DESCRIPTION:
LOTS 1 AND 2, BENINATI SUBDIVISION AND ALL OF THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 23, TOWNSHIP 1 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO DESCRIBED AS:
BEGINNING AT THE NORTHWEST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE SOUTH 89°42'50" EAST ALONG THE NORTH LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1331.67 FEET TO THE NORTHEAST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE SOUTH 00°29'54" EAST ALONG THE EAST LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1324.36 FEET TO THE SOUTHEAST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 89°29'47" WEST ALONG THE SOUTH LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1329.62 FEET TO THE SOUTHWEST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 00°35'27" WEST ALONG THE EAST RIGHT-OF-WAY LINE OF FRANKLIN STREET AND ALONG THE WEST LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1319.34 FEET TO THE POINT OF BEGINNING. CONTAINS 1,758,675 SQUARE FEET OR 40.374 ACRES MORE OR LESS.

WHEREAS, the Board of County Commissioners held a public hearing on the application on the 1st day of September, 2020; and

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that based upon the evidence presented at the hearing, the application in this case is hereby APPROVED based upon the following findings-of-fact and subject to the fulfillment of the following conditions by the applicant:

RECOMMENDED FINDINGS-OF-FACT
1. The final plat is consistent and conforms to the approved preliminary plat.

2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Recommended Conditions:

1. All utilities shall be located underground pursuant to the Adams County Development Standards and Regulations.
2. The property owner for the newly created parcel will be required to obtain an access permit prior to the issuance of a Certificate of Occupancy for any buildings on the site.

Recommended Note to the Applicant:

1. The applicant shall comply with all building, zoning, fire, engineering, and health codes and regulations during the development of the subject site.
2. The Colorado Division of Parks and Wildlife has requested that a survey of the property for nesting of burrowing owls occurs if earthmoving occurs between March 15th and October 31st of any given year. These raptors are classified as a state threatened species and are protected by both state and federal laws, including the Migratory Bird Treaty Act. These laws prohibit the killing of burrowing owls or disturbance of their nests. Guidelines for performing a burrowing owl survey can also be obtained from the local District Wildlife Manager.
3. Lot-specific geotechnical investigation, testing, and analysis will be needed, once building locations are identified and prior to building permit application, to determine depths to bedrock and seasonal groundwater levels, and to characterize soil and bedrock engineering properties such as expansion/consolidation potential, density, strength, water content, and allowable bearing pressures.
4. According to NRCS soil survey data, the site soils are moderately corrosive to uncoated steel. On lots where basements are planned and groundwater levels are sufficiently deep to allow below-grade construction, epoxy-coated, vinyl/composite/fiberglass, concrete, or otherwise corrosion-resistant basement window wells are recommended, rather than uncoated or galvanized steel.
5. Applicant must submit the recorded resolution of approval to the Division of Water Resources to allow for the additional well to be permitted on the newly created parcel.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

CASE NO.: PLT2020-00018

CASE NAME: JRJK Dream Acres Final Plat

TABLE OF CONTENTS

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

Board of County Commissioners September 1, 2020

CASE No.: **PLT2020-00018**	CASE NAME: **JRJK Dream Acres**
Owner's Name:	James and Kathleen Hill, Rhonda and Jerry Nelson
Applicant's Name:	James and Kathleen Hill
Applicant's Address:	13830 Franklin Street Brighton, Colorado 80602
Location of Request:	13830 and 13850 Franklin Street
Parcel Numbers:	0157323000010, 0157323002019, 0157323002018
Nature of Request:	Major Subdivision Final Plat
Current Zone District:	Agricultural-1
Proposed Uses:	Single-Family
Future Land Use:	Estate Residential
Total Site Area:	Approximately 40 acres
Hearing Date(s):	**BoCC: September 1st, 2020 / 9:30 a.m.**
Report Date:	August 5, 2020
Case Manager:	Layla Bajelan
Staff Recommendation:	APPROVAL with 7 Findings-of-Fact, 2 Conditions and 5 Notes

SUMMARY OF PREVIOUS APPLICATIONS

On February 25, 2020, the Board of County Commissioners approved a major subdivision preliminary plat and rezone from A-3 to A-1 for JRJK Dream Acres to create three lots from three existing parcels.

SUMMARY OF APPLICATIONS

Background:

The applicants, James and Kathleen Hill, are requesting a major subdivision final plat. The plat request encompasses three existing parcels in the vicinity of 13830 and 13850 Franklin Street. The subdivision application will allow for the two existing property owners to incorporate acreage from the larger parcel into their established lots. There would be one A-1 lot established with this request, however the total number of parcels would remain the same. This newly created lot could be developed with one single-family dwelling.

As proposed, the majority of the land would be incorporated into the applicant's parcel (13830 Franklin Street), which would be Lot 1 and consist of 27.6 acres. In addition, the property to the north would also incorporate a portion of the land from the 35-acre parcel, which would become Lot 2 and consist of 7.3 acres. There would be a third lot, Lot 3, that would be created and consist of 5.4 acres. As shown on the plat, easements and setback buffers are in place for the existing oil and gas wells on the proposed 5.4-acre parcel.

Several years ago, in 2015, the 35-acre property was the proposed location of the Wadley Farms well pad. Synergy Resources Corp. proposed to construct a 20-well well pad on this parcel, which would have been the first large urban mitigation facility within the County, within 500-ft from at least 22 homes. Due to the significant amount of pushback the operator received, the well pad was relocated to a parcel north of Wadley Farms and away from residents. This new site, named the Ivey well pad, was permitted in 2017 by the Board of County Commissioners with the condition that the operator never allow the Wadley Farms property to be drilled for oil and gas. After the approval of the Ivey well pad, Ward Petroleum sold the surface development rights to the applicant. This relocation of the well pad protected the neighborhood from being within a couple hundred feet of a large oil and gas facility and was the first major success story where citizens came together to pressure operators to find a more appropriate location.

Development Standards and Regulations Requirements Major Subdivision (Final Plat):

Per Section 2-02-19-04 of the County's Development Standards and Regulations, a final plat must be consistent and conform to an approved preliminary plat. On February 25, 2020, the Board of County Commissioners approved a preliminary plat on the subject property. The subject request conforms to the approved preliminary plat.

The proposed plat conforms to the criteria for approval for a major subdivision final plat as outlined in Section 2-02-19-04-05 of the County's Development Standards. These standards include conformance to the County's Comprehensive Plan, the subdivision design standards, evidence of adequate water and sewer supply, adequate drainage improvements, adequate public infrastructure, and compatibility with the surrounding area. Per Section 5-03-03 of the County's Development Standards and Regulations, subdivision plats and lot dimensions are required to conform to requirements of the zone district in which the property is located. In addition, all lots created by a subdivision shall have access to a County-maintained right-of-way. The property is located within the Agriculture-1 (A-1) zone district which has a minimum of 2.5-acre lot size and a minimum lot width of 150-feet for lots with individual well and septic systems. The proposed subdivision will be served by individual well and septic system and all lots conform to the minimum dimensional requirements for the A-1 zone district. In addition, all the proposed lots will have access to a public right-of-way and will be accessed from Franklin Street to the west.

The applicant has also provided evidence of adequate water and sewer to service the property. Two of the three lots are currently being serviced by individual well and septic. The Colorado Division of Water Resources reviewed the project and confirmed the availability of adequate water supply to support the development and the additional individual residential well that will be required to develop on the newly created parcel. Tri-County Health Department also reviewed the subject request and had no objection to the proposed subdivision utilizing onsite wastewater

treatment systems (OWTS), provided that the OWTS is permitted, installed, and operated in compliance with regulation.

Subdivision Improvement Agreement (SIA):
Per Section 5-02-04 of the County's Development Standards and Regulations, a subdivision improvement agreement (SIA) is required with a final plat. The SIA allows for construction of infrastructure, such as public streets and storm sewers, to be constructed on the property. Through the Engineering Review, it was determined that a subdivision improvement agreement (SIA) will not be required with this application. The residents of the neighboring Wadley Farms Subdivision appreciate the agrarian feel of the area, which was taken into consideration during the review and has resulted in no required improvements to the gravel roads.

In addition, residential subdivisions, public land dedication is required to support regional parks and school districts. Section 5-05-05-04 of the County's Development Standards allows for cash-in-lieu of land dedication. These cash-in-lieu fees were required to be paid prior to scheduling the final plat application for public hearing.

Zone District Regulations:
The zoning designation for all parcels within this subdivision is A-1. Per Section 3-08-01 of the County's Development Standards and Regulations, the purpose of the A-1 zone district is to provide a rural single-family dwelling district where the minimum lot area for a home site is intended to provide for a rural living experience. Limited farming uses are permitted, including the keeping of a limited number of animals for the utilization and enjoyment of the County's rural environment. Primary uses within the A-1 zone district include single-family residential, farming, and nurseries. The dimensional requirements for the A-1 zone district include a minimum of 2.5-acre lot size and a minimum lot width of 150-feet for lots with individual well and septic systems.

The proposed plat will create one new lot, Lot 3, consisting of approximately 5.4 acres and 380 feet of lot width. Lot 2 will incorporate additional acreage into the existing lot and will consist of 7.3 acres and have 513 feet of lot width. Lot 1 will consist of 27 acres and have 233 feet of lot width. Therefore, all lots will be in conformance with the dimensional standards for the A-1 zone district of Section 3-08-07 of the County's Development Standards.

Future Land Use Designation/Comprehensive Plan:
The future land use designation on the properties is Estate Residential. Per Chapter 5 of the Adams County Comprehensive Plan, the purpose of the Estate Residential future land use designation is to provide limited opportunities for ex-urban or rural lifestyles in the County. Estate Residential areas are designated for single-family housing at lower densities, typically no greater than one unit per acre, and compatible uses such as schools and parks. Approval of this subdivision request will help to support the County's long-term goal outlined in the Comprehensive Plan for providing estate residential areas, supporting the need for housing within the County.

This request would also be supported by the Comprehensive Plan, as Policy 11.1 *Permit Estate Residential Development in targeted locations* aims to allow Estate Residential development

only where a similar land use pattern is already established or where such patterns may be appropriately extended. Policy 11.1.a. *Established Areas* allows for Estate Residential development as an appropriate land use only in areas established for such development in area designated on the Future Land Use map.

Site Characteristics:
The subject properties have street frontage along Franklin Street to the west. The subject request contains three existing parcels. The subdivision request will shift lot lines to create three newly configured parcels. The existing properties are home to two single-family residential dwellings, each on their own individual parcels, and an undeveloped 35-acre parcel. The properties containing the single-family dwellings are in the Benninati Subdivision, however the vacant, 35-acre property in not within a platted subdivision. All parcels surrounding the subject parcels are within the Wadley Farms subdivision. The Wadley Farms subdivision consists of several single-family lots that provide for a rural lifestyle. No existing buildings will be removed as a result of the subdivision application.

Surrounding Zoning Designations and Existing Use Activity:

Northwest **A-1** **Single-family dwelling**	**North** **A-1** **Single-family dwelling**	**Northeast** **A-1** **Single-family dwelling**
West **A-1** **Single-family dwelling**	**Subject Property** **A-1** **SF Dwellings/vacant**	**East** **A-1** **Single-family dwelling**
Southwest **A-1** **Single-family dwelling**	**South** **A-1** **Single-family dwelling**	**Southeast** **A-1** **Single-family dwelling**

Compatibility with the Surrounding Area:
The surrounding properties are all zoned as A-1 and are developed with single-family dwellings and associated accessory structures.

Per Section 8-02-02 of the County's Development Standards and Regulations, a traffic study is required with these applications. Staff reviewed the traffic study and has no outstanding concerns with potential traffic generation from the site. Although the surrounding roads are gravel, they are beloved by the residents and help to preserve the rural character within the square mile enclave that is surrounded by the City of Thornton. A new traffic study may be required during review of any building permit for new development on the property.

This application is compatible with the overall area and is not detrimental to public health and safety. Approval of this request will be consistent with the character of existing development in the area.

Staff Recommendations:

Based upon the application, the criteria for approval of a final plat, and recent site visit, staff recommends approval of this request with 7 findings-of-fact, 2 conditions, and 5 notes.

RECOMMENDED FINDINGS-OF-FACT

1. The final plat is consistent and conforms to the approved preliminary plat.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Recommended Conditions:

1. All utilities shall be located underground pursuant to the Adams County Development Standards and Regulations.
2. The property owner for the newly created parcel will be required to obtain an access permit prior to the issuance of a Certificate of Occupancy for any buildings on the site.

Recommended Note to the Applicant:

1. The applicant shall comply with all building, zoning, fire, engineering, and health codes and regulations during the development of the subject site.
2. The Colorado Division of Parks and Wildlife has requested that a survey of the property for nesting of burrowing owls occurs if earthmoving occurs between March 15th and October 31st of any given year. These raptors are classified as a state threatened species and are protected by both state and federal laws, including the Migratory Bird Treaty Act. These laws prohibit the killing of burrowing owls or disturbance of their nests. Guidelines for performing a burrowing owl survey can also be obtained from the local District Wildlife Manager.
3. Lot-specific geotechnical investigation, testing, and analysis will be needed, once building locations are identified and prior to building permit application, to determine depths to bedrock and seasonal groundwater levels, and to characterize soil and bedrock engineering properties such as expansion/consolidation potential, density, strength, water content, and allowable bearing pressures.

4. According to NRCS soil survey data, the site soils are moderately corrosive to uncoated steel. On lots where basements are planned and groundwater levels are sufficiently deep to allow below-grade construction, epoxy-coated, vinyl/composite/fiberglass, concrete, or otherwise corrosion-resistant basement window wells are recommended, rather than uncoated or galvanized steel.
5. Applicant must submit the recorded resolution of approval to the Division of Water Resources to allow for the additional well to be permitted on the newly created parcel.

COUNTY AGENCY COMMENTS

Staff reviewed the request and has no outstanding concerns with the proposed applications.

REFERRAL AGENCY COMMENTS

Responding with Concerns:

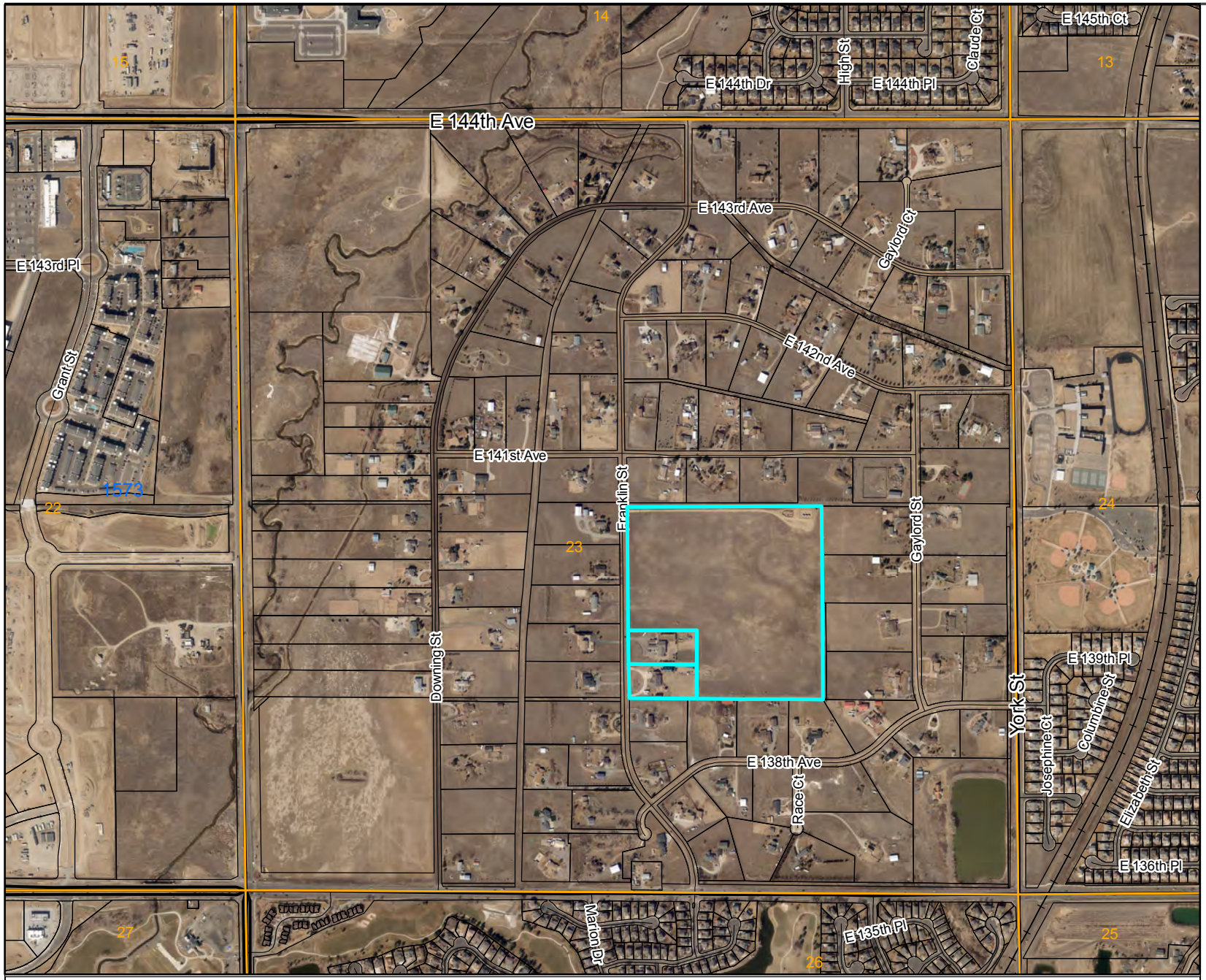
None

Responding without Concerns:

Brighton School District 27J
Colorado Department of Transportation (CDOT)
Colorado Division of Water Resources (CDNR-DWR)
Colorado Division of Wildlife
Colorado Geological Survey (CGS)
Tri County Health Department (TCHD)
Xcel Energy

Notified but not Responding / Considered a Favorable Response:

Adams County Sheriff
Adams County Parks and Open Space
Amber Creek Metro District
Century Link
City of Northglenn
City of Thornton
City of Westminster
Colorado Div. of Mining Reclamation and Safety
Colorado Division of Wildlife
Colorado Geological Survey (CGS)
Comcast
Metro Wastewater Reclamation
North Metro Fire District
Regional Transportation District (RTD)
Union Pacific Railroad
U.S. Environmental Protection Agency
U.S. Post Office
Wadley Farms HOA



Legend

- Railroad
- Major Water
- Zoning Line
- Sections

Zoning Districts

- A-1
- A-2
- A-3
- R-E
- R-1-A
- R-1-C
- R-2
- R-3
- R-4
- M-H
- C-0
- C-1
- C-2
- C-3
- C-4
- C-5
- I-1
- I-2
- I-3
- CO
- PL
- AV
- DIA
- P-U-D
- P-U-D(P)

PRC2018-00025; JRJK Dream Acres (Wadley Farms)

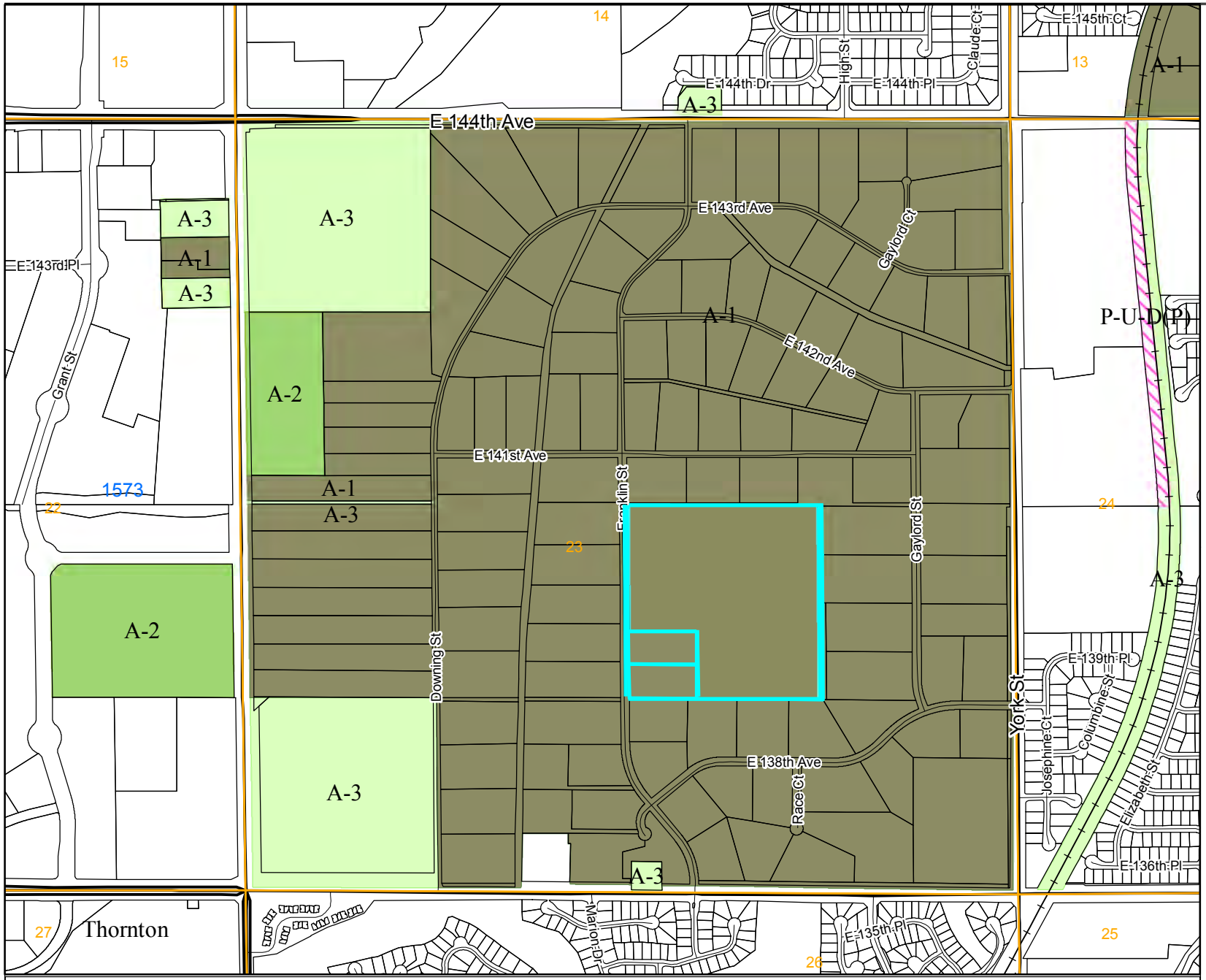
Aerial Map

N

For display purposes only.

ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy



Legend

- Railroad
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- R-E
- R-1-A
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- R-4
- M-H
- C-0
- C-1
- C-2
- C-3
- C-4
- C-5
- I-1
- I-2
- I-3
- CO
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- P-U-D(P)

PRC2018-00025; JRJK Dream Acres (Wadley Farms)

Current Zoning Map

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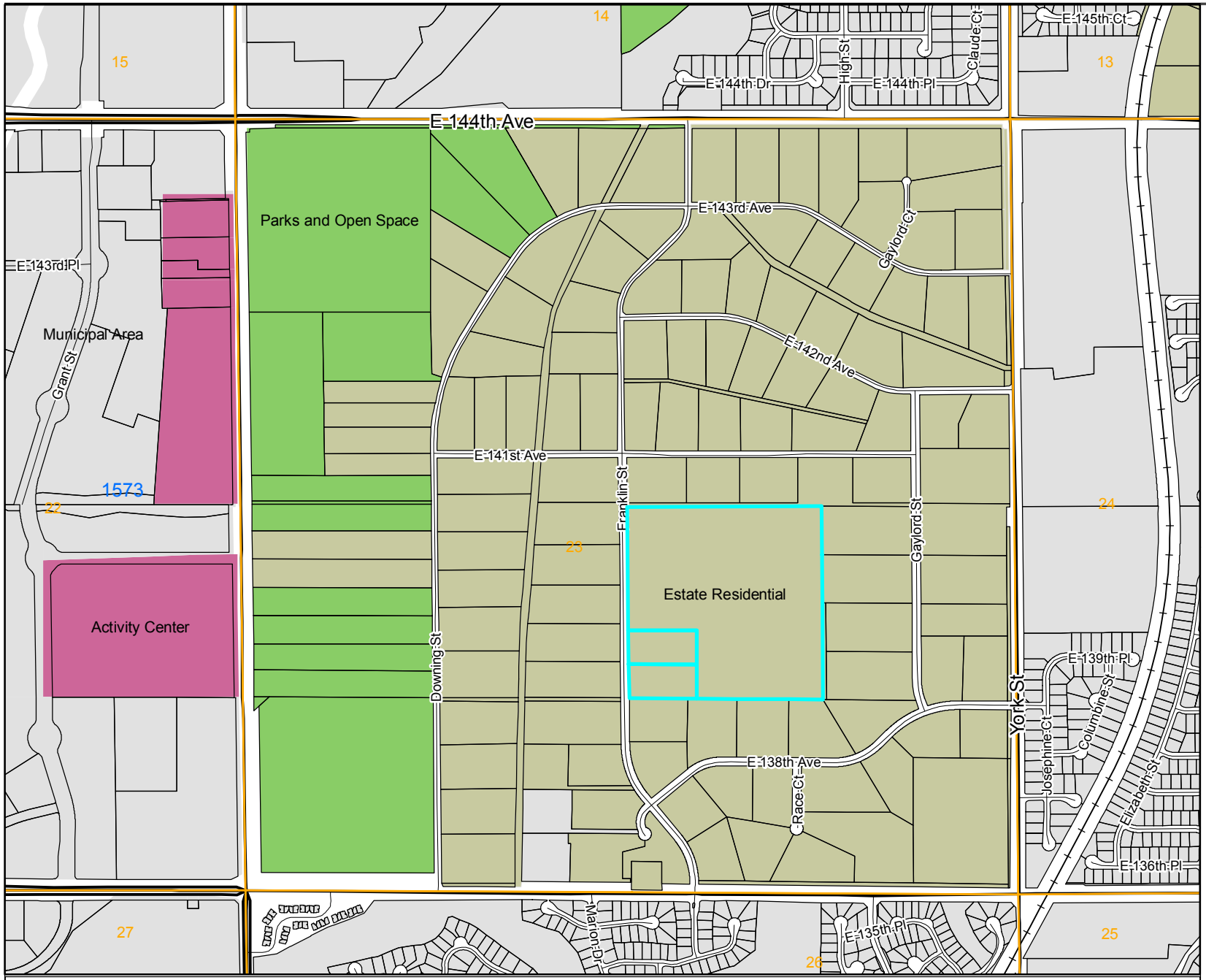
For display purposes only.

ADAMS COUNTY COLORADO



Legend

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- A-1
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- A-3
- R-E
- R-1-A
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- R-3
- R-4
- M-H
- C-0
- C-1
- C-2
- C-3
- C-4
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- I-3
- CO
- PL
- AV
- DIA
- P-U-D
- P-U-D(P)

PRC2018-00025; JRJK Dream Acres (Wadley Farms)

Future Land Use Map

N

For display purposes only.

ADAMS COUNTY COLORADO

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DEVELOPMENT APPLICATION

13830 FRANKLIN STREET (35 ACRE TRACT)
BRIGHTON COLORADO

The 35 acre Tract of land is located in the Wadley Farms Subdivision in Adams County. The property is vacant land except for an oil/gas facility at the northeast corner. That operation is located on a 400' X 600' surface easement. The 35 acres is zoned A=3 Agricultural and has direct access to Franklin Street.

James J. Hill and Kathleena Hill purchased the 35 acres in order to add land to their Lot 2 in the Benninati Subdivision. Neighbors Terry an Rhonda Nelson agreed to purchase some of the land to add to their Lot 1 in the Benninati Subdivision. The Hills decided to add a 5 acre site for home that could have been built on the 35 acres. This plan divides the 35 acre into 3 lots.

Conceptual Review Application

The Applicant filed a Conceptual Review Application that was reviewed by the Development Review Team. Following the Conceptual Review Meeting the Review Team provided written comments to the Applicant dated5/1/2018. Comments were reviewed by the Applicant and his Consultants as to County Regulations and design criteria.

As part of the Conceptual Review the Applicant is required to hold a Neighborhood Meeting. This meeting was held on August 3, 2018 from 6:30 to 7 00 on the franklin Street property. The Applicant mailed out letters to 106 property owners and associated organizations. This list was provided by the County. Eleven neighbors attended the meeting including Jay and Kathy Hill and Rhonda Nelson. There was one person that requested information via email from the consultants and a neighbor that contacted the Hills after the meeting. A detailed account of Neighborhood Meeting is attached to this Application.

Zoning

The A-3 Zoning District has a minimum lot size of 35 acres. Under that zoning restriction the Hills are not able to divide the property as shown on the Preliminary Plat. Since the surrounding Wadley Farms Subdivision is zoned A-1, the rezoning of the 35 acre Tract to A-1 would be the best zone to implement the Preliminary plat.

The County Future Land Use Plan shows the 35 acres in the same Estate Residential classification as Wadley Farms. A review of the surrounding land use supports this zoning request from A-3 to A-1. The Wadley Farms Subdivision was developed as an Estate Residential area under the A-1 zoning district with a minimum lot size of 2.5 acres. The Preliminary Plat with 3 lots is a much lower density than Wadley Farms, so will have little or no impact on the adjoining Wadley farms neighborhood.

Preliminary Plat.

The zoning change to A-1 will allow the division of the property into 3 lots. The Preliminary Plat maintains the same density that's available under the existing zoning. The difference is that you have two expanded lots and one 5 acre lot instead of two 2.5 acre lots and one 35 acre lot.

The property has direct access to Franklin Street for all three lots. Adding a one home to this Preliminary Plat should not have any appreciable impact on Franklin Street.

Development Application

The Applicant requests a zoning change on the entire 35 acre property from A-3 to A-1 to facilitate the development of the Preliminary Plat. Preliminary Plat to divide the property into 3 lots as shown on thelat.

JRJK DREAM ACRES

LOTS 1 AND 2, BENINATI SUBDIVISION AND THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SECTION 23, TOWNSHIP 1 SOUTH, RANGE 68 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO.

CASE NO. PLT2020-00018

SHEET 1 OF 2

DEDICATION AND OWNERSHIP:

KNOW ALL MEN BY THESE PRESENTS THAT THE UNDERSIGNED, BEING THE OWNER(S) OF OF THE FOLLOWING DESCRIBED TRACT OF LAND:

LOTS 1 AND 2, BENINATI SUBDIVISION AND ALL OF THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF SECTION 23, TOWNSHIP 1 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO DESCRIBED AS:
BEGINNING AT THE NORTHWEST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE SOUTH 89°42'50" EAST ALONG THE NORTH LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1331.67 FEET TO THE NORTHEAST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE SOUTH 00°29'54" EAST ALONG THE EAST LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1324.36 FEET TO THE SOUTHEAST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 89°29'47" WEST ALONG THE SOUTH LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1329.62 FEET TO THE SOUTHWEST CORNER OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 00°35'27" WEST ALONG THE EAST RIGHT-OF-WAY LINE OF FRANKLIN STREET AND ALONG THE WEST LINE OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SAID SECTION 23, A DISTANCE OF 1319.34 FEET TO THE POINT OF BEGINNING.
CONTAINS 1,758,675 SQUARE FEET OR 40.374 ACRES MORE OR LESS.

HAVE BY THESE PRESENTS LAID OUT, PLATTED AND SUBDIVIDED THE SAME INTO LOTS AND EASEMENTS AS SHOWN ON THIS PLAT UNDER THE NAME AND STYLE OF JRJK DREAM ACRES. THE UNDERSIGNED DOES HEREBY DEDICATE, GRANT AND CONVEY TO ADAMS COUNTY THOSE PUBLIC EASEMENTS AS SHOWN ON THIS PLAT; AND FURTHER RESTRICTS THE USE OF ALL PUBLIC EASEMENTS TO ADAMS COUNTY AND/OR ITS ASSIGNS, PROVIDED HOWEVER, THAT THE SOLE RIGHT AND AUTHORITY TO RELEASE OR QUITCLAIM ALL OR ANY SUCH PUBLIC EASEMENTS SHALL REMAIN EXCLUSIVELY VESTED IN ADAMS COUNTY.

EXECUTED THIS _____ DAY OF _____, 20_____.

FOR MOUNTAIN VIEW AT WADLEY FARMS LLC, A COLORADO LIMITED LIABILITY COMPANY:

_____
JAMES J. HILL, MANAGER

ACKNOWLEDGMENT:

STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING PLAT AND DEDICATION WERE ACKNOWLEDGED BEFORE ME THIS _____ DAY OF _____, 20_____, BY JAMES J. HILL, MANAGER, MOUNTAIN VIEW AT WADLEY FARMS LLC, A COLORADO LIMITED LIABILITY COMPANY, AS OWNER PF LOT 3

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____

_____ _____
JAMES J. HILL KATHLEENA HILL

ACKNOWLEDGMENT:

STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING PLAT AND DEDICATION WERE ACKNOWLEDGED BEFORE ME THIS _____ DAY OF _____, 20_____, BY JAMES J. HILL AND KATHLEENA HILL, AS OWNER OF LOT 1.

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____

_____
RHONDA J. NELSON

ACKNOWLEDGMENT:

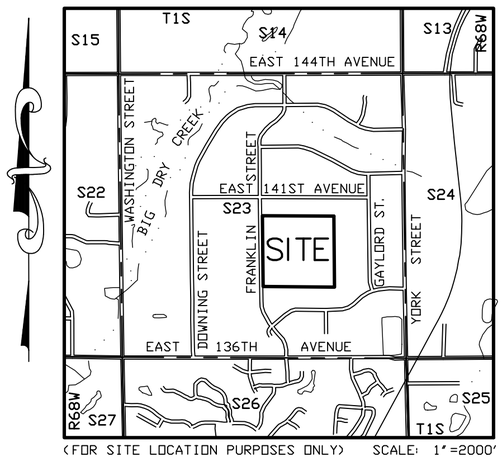
STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING PLAT AND DEDICATION WERE ACKNOWLEDGED BEFORE ME THIS _____ DAY OF _____, 20_____, BY RHONDA J. NELSON, AS OWNER OF LOT 2.

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____

VICINITY MAP

SCALE: 1"=2000'



(FOR SITE LOCATION PURPOSES ONLY) SCALE: 1"=2000'

PLAT NOTES:

1. THE POLICY OF THE COUNTY REQUIRES THAT MAINTENANCE ACCESS BE PROVIDED TO ALL STORM DRAINAGE FACILITIES TO ASSURE CONTINUOUS OPERATIONAL CAPABILITY OF THE SYSTEM. THE PROPERTY OWNERS SHALL BE RESPONSIBLE FOR THE MAINTENANCE OF ALL DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS LOCATED ON THEIR LAND UNLESS MODIFIED BY SUBDIVISION DEVELOPMENT AGREEMENT. SHOULD THE OWNER FAIL TO ADEQUATELY MAINTAIN SAID FACILITIES, THE COUNTY SHALL HAVE THE RIGHT TO ENTER SAID LAND FOR THE SOLE PURPOSE OF OPERATIONS AND MAINTENANCE. ALL SUCH MAINTENANCE COSTS WILL BE ASSESSED TO THE PROPERTY OWNER.

2. THIS PARCEL OF LAND LIES WITHIN ZONE X (AREAS DETERMINED TO BE OUTSIDE THE 0.2% ANNUAL CHANCE FLOODPLAIN AS DELINEATED IN THE F.E.M.A., FLOOD INSURANCE RATE MAP, MAP NUMBER 08001C0304J, MAP REVISED JANUARY 20, 2016.

3. THE LINEAL UNITS USED AND SHOWN HEREON IS U. S. SURVEY FOOT.

4. UTILITY EASEMENTS MAY BE REQUIRED AROUND THE PERIPHERY OF THE LOTS.

5. OIL AND GAS OPERATIONS: EACH BUYER OF A LOT IN THIS SUBDIVISION ACKNOWLEDGES AND AGREES THAT (1) THERE ARE CONTINUING OIL AND GAS OPERATIONS IN AND AROUND THE EXISTING WELLS AND/OR PRODUCTION SITES (2) THERE MAY BE FUTURE WELLS AND PRODUCTION SITES DRILLING ASSOCIATED OIL AGREEMENTS ENTERED INTO WITH ENCANA CORPORATION AND KP KAUFMAN INC.

6. THIS SURVEY DOES NOT CONSTITUTE A TITLE SEARCH BY R.W. BAYER & ASSOCIATES, INC. OF THE PROPERTY SHOWN AND DESCRIBED HEREIN TO DETERMINE OWNERSHIP OF THE TRACT OF LAND, COMPATIBILITY OF THIS DESCRIPTION WITH THOSE OF ADJACENT TRACTS OF LAND OR RIGHTS-OF-WAY, EASEMENTS OR ENCUMBRANCES OF RECORD AFFECTING THIS TRACT OF LAND. R.W. BAYER & ASSOCIATES, INC. HAS RELIED UPON FIRST AMERICAN TITLE INSURANCE COMPANY, COMMITMENT NO. NCS-885521-CO, DATED DECEMBER 29, 2018 AT 5:00 P.M., FOR OWNERSHIP AND FOR THE PURPOSE OF SHOWING RECORDED EASEMENTS AND RIGHT-OF-WAY ACROSS THESE PREMISES.

Prepared By:

R. W. BAYER & ASSOCIATES, INC.
12170 TEJON STREET, UNIT 700
WESTMINSTER, COLORADO 80234
(303)452-4433 rwbsurveying@hotmail.com
CAD FILE: H18062/H18062A.DWG

Date Prepared: APRIL 13, 2018
02-20-2020 REVISED PER CO COMMENTS
07-07-2020 PER NEW O&E REPORT

NOTICE:

ACCORDING TO COLORADO LAW YOU MUST COMMENCE ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY WITHIN THREE YEARS AFTER YOU FIRST DISCOVER SUCH DEFECT. IN NO EVENT MAY ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY BE COMMENCED MORE THAN TEN YEARS FROM THE DATE OF THE CERTIFICATION SHOWN HEREON.

THIS SURVEY DOES NOT CONSTITUTE A TITLE SEARCH BY R.W. BAYER & ASSOCIATES, INC. OF THE PROPERTY SHOWN AND DESCRIBED HEREIN TO DETERMINE OWNERSHIP OF THE TRACT OF LAND, COMPATIBILITY OF THIS DESCRIPTION WITH THOSE OF ADJACENT TRACTS OF LAND OR RIGHTS-OF-WAY, EASEMENTS OR ENCUMBRANCES OF RECORD AFFECTING THIS TRACT OF LAND. R.W. BAYER & ASSOCIATES, INC. HAS RELIED UPON FIRST AMERICAN TITLE INSURANCE COMPANY, OWNER & ENCUMBRANCES REPORT, FILE NO. NCS-EODEN823-CO, DATED JUNE 24, 2020 AT 5:00 P.M., FOR OWNERSHIP AND FOR THE PURPOSE OF SHOWING RECORDED EASEMENTS AND RIGHT-OF-WAY ACROSS THESE PREMISES.

BASIS FOR BEARINGS:

THE NORTH LINE (THE N.W. COR. IS A 3-1/4" ALUMINUM CAP, P.L.S. 37971, 2007, FLUSH W/ GROUND AND THE N.E. COR. IS A 3-1/4" ALUMINUM CAP, P.L.S. 38285, FLUSH W/GROUND) OF THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SECTION 23, TOWNSHIP 1 SOUTH RANGE 68 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, IS ASSUMED TO BEAR SOUTH 89°42'50" EAST. ALL OTHER BEARINGS ARE RELATIVE THERETO. MONUMENTS ARE AS SHOWN HEREON.

SURVEYOR'S CERTIFICATE:

I, RAYMOND W. BAYER, A REGISTERED LAND SURVEYOR, REGISTERED IN THE STATE OF COLORADO, DO HEREBY CERTIFY THAT THERE ARE NO ROADS, PIPELINES, IRRIGATION DITCHES OR OTHER EASEMENTS IN EVIDENCE OR KNOWN BY ME TO EXIST ON OR ACROSS THE HEREINBEFORE DESCRIBED PROPERTY, EXCEPT AS SHOWN ON THIS PLAT. I FURTHER CERTIFY THAT THIS SURVEY WAS PERFORMED BY ME OR UNDER MY DIRECT RESPONSIBILITY, SUPERVISION AND CHECKING, AND THAT THIS PLAT ACCURATELY REPRESENTS SAID SURVEY, AND THAT ALL MONUMENTS EXIST AS SHOWN HEREON.

RAYMOND W. BAYER
REG. L.S. NO. 6973

BOARD OF COUNTY COMMISSIONERS APPROVAL:

APPROVED BY THE ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS THIS _____ DAY OF _____, 20_____.

_____
CHAIR

CERTIFICATE OF THE CLERK AND RECORDER:

THIS PLAT WAS FILED FOR RECORD IN THE OFFICE OF THE ADAMS COUNTY CLERK AND RECORDER, IN THE STATE OF COLORADO, AT _____:_____ _____.M., ON THE _____ DAY OF _____, AD., 20 _____.

BY: _____ _____
DEPUTY COUNTY CLERK AND RECORDER

RECEPTION NO: _____

JRJK DREAM ACRES

LOTS 1 AND 2, BENINATI SUBDIVISION AND THE NORTHWEST ONE-QUARTER OF THE SOUTHEAST ONE-QUARTER OF SECTION 23, TOWNSHIP 1 SOUTH, RANGE 68 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO.

SHEET 2 OF 2

CASE NO. PLT2020-00018

N. W. COR. N. W. 1/4, S. E. 1/4, SEC. 23, T. 1S., R. 68W. (FOUND 3-1/4" ALUMINUM CAP, P. L. S. 37971, 2007, FLUSH W/ GROUND)

POINT OF BEGINNING

60'

LOT 1

LOT 2

25' TRAIL RESERVED TO ADAMS COUNTY

BLOCK 9, WADLEY FARMS SUBDIVISION SECOND FILING (FILE 14, MAP 334, ADAMS COUNTY RECORDS)

LOT 3

LOT 4

S89°42' 50"E 1331. 67'

N. E. COR. N. W. 1/4, S. E. 1/4, SEC. 23, T. 1S., R. 68W. (FOUND 3-1/4" ALUMINUM CAP, P. L. S. 38285, 2013, FLUSH W/GROUND)

25' ROAD EASEMENT, RECEPTION NO. 2010000038767, ADAMS COUNTY RECORDS

30' PIPELINE EASEMENT, RECEPTION NO. 2010000038767, ADAMS COUNTY RECORDS

NORTH LINE N. W. 1/4, S. E. 1/4, SEC. 23 (BASIS FOR BEARINGS)

192. 65'

SEPARATORS

TANK BATTERY

LOT 1

CONTAINS 1, 202, 863 SQUARE FEET
OR 27. 614 ACRES MORE OR LESS
13830 FRANKLIN STREET

250' WELL SETBACK
NO STRUCTURES

WELLS/VALVES

KP KAUFFMAN COMPANY, INC.
N. WASHINGTON 1-23, API #001-09655
N. WASHINGTON 2-23, API #001-09677
N. WASHINGTON 8-23, API #001-09666

400' x600' OIL/GAS OPERATION AREA & EASEMENT, RECEPTION NO'S. 2010000038767, 2013000081378 & 2013000080130, ADAMS COUNTY RECORDS

S89° 29' 47"E 622. 28'

1319. 34'

380. 00'

LOT 3

CONTAINS 236, 423 SQUARE FEET
OR 5. 428 ACRES MORE OR LESS
13978 FRANKLIN STREET

380. 00'

S00° 35' 27"E

FIRST FILING LOT 1

SUBDIVISION LOT 2

N

W E

S

0 50' 100' 200'

SCALE: 1"=100'

LEGEND

- DENOTES: FOUND ALIQUOT CORNER AS DESCRIBED HEREIN
- ■ DENOTES: FOUND MONUMENT AS DESCRIBED HEREIN
- ● DENOTES: SET #5 REBAR & CAP, BAYER - P. L. S. 6973, FLUSH W/GROUND
- "PER PLAT" DENOTES: FROM THE PLAT OF BENINATI SUBDIVISION

WEST LINE N. W. 1/4 S. E. 1/4 SEC. 23

30' ACCESS, INGRESS & EGRESS & UTILITY EASEMENT TO THE OWNERS OF LOTS 1, 2 & 3 BY THIS PLAT

S89° 29' 47"E 622. 28'

30' ACCESS, INGRESS & EGRESS & UTILITY EASEMENT TO THE OWNERS OF LOTS 1, 2 & 3 BY THIS PLAT

N.W. 1/4 S.E. 1/4 SECTION 23, T.1S., R.68W.

EAST LINE N. W. 1/4 S. E. 1/4 SEC. 23

FOUND #4 REBAR 2. 2' EAST OF CORNER

S00° 29' 54"E 1324. 36'

LOT 2

CONTAINS 319, 389 SQUARE FEET
OR 7. 332 ACRES MORE OR LESS
13850 FRANKLIN STREET

N00° 35' 27"W

513. 35'

513. 35'

S00° 35' 27"E

332. 12'

BLOCK 15, WADLEY FARMS SUBDIVISION SECOND FILING (FILE 14, MAP 334, ADAMS COUNTY RECORDS)

FRANKLIN STREET
60' RIGHT-OF-WAY PER WADLEY FARMS SUBDIVISION FIRST AND SECOND FILING

FOUND #4 REBAR & CAP, P. L. S. 6973, FLUSH

WADLEY FARMS ADAMS COUNTY RECORDS)

LOT 3

FOUND #4 REBAR & CAP, P. L. S. 6973, FLUSH

10' UTILITY & DRAINAGE EASEMENT PER WADLEY FARMS SUBDIVISION FIRST FILING (TYPICAL)

25' TRAIL EASEMENT (RESERVED) PER WADLEY FARMS SUBDIVISION FIRST FILING

LOT 1 SUBDIVISION COUNTY RECORDS)

S89° 29' 47"E 622. 28'

BENINATI FILE 17, MAP 285, ADAMS

233. 34'

329. 84' (M)

BLOCK 10, (FILE 14, MAP 326,

LOT 4

LOT 1

CONTAINS 1, 202, 863 SQUARE FEET
OR 27. 614 ACRES MORE OR LESS
13830 FRANKLIN STREET

LOT 2

SOUTH LINE N. W. 1/4 S. E. 1/4 SEC. 23

10' NON-EXCLUSIVE IRRIGATION OR DOMESTIC WATER PIPELINE EASEMENT, BOOK 2527 PAGE 259, ADAMS COUNTY RECORDS

FOUND #5 REBAR & CAP, P. L. S. 6973, FLUSH

S. E. COR. N. W. 1/4, S. E. 1/4, SEC. 23, T. 1S., R. 68W. (FOUND #4 REBAR, 0. 5' DEEP)

S. W. COR. N. W. 1/4, S. E. 1/4, SEC. 23, T. 1S., R. 68W. FOUND 3-1/4" ALUMINUM CAP, P. L. S. 38285, 2013, FLUSH W/GROUND)

466. 69'

N89° 29' 47"W 1329. 62'

60'

LOT 1, J & B ESTATES (FILE 17, MAP 245, ADAMS COUNTY RECORDS)

LOT 2 LOT 3 BLOCK 12, WADLEY FARMS SUBDIVISION FIRST FILING (FILE 14, MAP 326, ADAMS COUNTY RECORDS)

10' UTILITY & DRAINAGE EASEMENT PER WADLEY FARMS SUBDIVISION FIRST FILING (TYPICAL)

LOT 4

LOT 5

Prepared By:
R. W. BAYER & ASSOCIATES, INC.
12170 TEJON STREET, UNIT 700
WESTMINSTER, COLORADO 80234
(303) 452-4433 rwbsurveying@hotmail. com
CAD FILE: H18062/H18062A. DWG

Date Prepared: APRIL 13, 2018
02-20-2020 REVISED PER CO COMMENTS
07-07-2020 PER NEW O&E REPORT

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Development Review Team Comments

Date: June 11th, 2020
Project Number: PLT2020-00018
Project Name: **JRJK Dreams Final Plat**

Note to Applicant:
The following review comments and information from the Development Review Team is based on the information you submitted for the Final Plat request application. The Development Review Team review comments may change if you provide different information during the Resubmittal. Please contact the case manager if you have any questions.

Also, please note where "Section" is referenced, it is referring to the appropriate section of the Adams County Development Standards and Regulations.

Commenting Division: **Development Services, Planning**
Name of Reviewer: Layla Bajelan
Email: LBajelan@adcogov.org / **720-523-6863**

PLN01: REQUEST
Applicant is requesting a Major Subdivision Final Plat to create three lots from three existing parcels.

PLN02: PUBLIC LAND DEDICATION
1. Public Land Dedication- School District, Neighborhood/ Regional Parks
2. Cash in Lieu being required
3. Included is a calculation sheet of PLD fees, once your case has been scheduled for Public Hearing, you will be expected to pay $1,358.69, at least 24 hours before your case has been scheduled.
4. Please do not pay this amount until your case has been scheduled for Public Hearing

PLN03: WATER SUPPLY
1. Department of Water Resources (DWR) has indicated that they will not support this subdivision until the existing wells on the property are re-permitted. Applicant must get approval/support from the DWR before this case will be scheduled for Public Hearing.

PLN04: CRITERIA FOR APPROVAL

Section 2-02-19-04-05

The Planning Commission, in making their recommendation, and the Board of County Commissioners, in approving a final plat, shall find.

1. The final plat is consistent and conforms to the approved preliminary plat.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Commenting Division: Development Services, Engineering:
Name of Review: Matt Emmens
Email: MEmmens@adcogov.org **/ 720-523-6826**

ENG01: Applicant has satisfied all engineer review requirements.

Commenting Division: Development Services, Right-of-Way Review
Name of Review: Holden Pederson/ Mark Alessi
Email. MAlessi@adcogov.org / **720-523-68**

ROW1: Please contact Eden Steele at ESteele@adcogov.org for addressing of three newly created lots.

ROW2: Additional comments provided on Plat Redline document

Commenting Division: Environmental Analyst Review

Name of Review: Katie Keefe
Email. KKeefe@adcogov.org/ **720-523-6886**

Note: Pursuant to Section 4-06-01-02-01-12, where a new home and/or other permanent structure with plumbing is constructed within three hundred (300) feet of an existing oil and gas well, the property owner shall submit a signed waiver acknowledging the existence of the facility

Commenting Division: Development Services Building and Safety, Chief Building Official
Name of Review: Justin Blair
Email: jblair@adcogov.org / **720-523-6843**

No Comment

Commenting Division: Parks
Name of Review: Aaron Clark
Email: aclark@adcogov.org

No Comment

Single-Family Residential and A-1 or RE zoning	
Number of Units=	3
Population generated=	9.8340
Student population generated=	2.3250
School Acreage Needed=	0.0605
Regional Park Acreage Needed=	0.0390
Total Acres of PLD Needed=	**0.0995**
Land Value per acre=	$13,662.00
PLD Fee in lieu=	**$1,358.69**
Deposits:	
School District { } Account=	**$825.87**
Regional Parks Account=	**$532.82**

From: Kerrie Monti
To: Layla Bajelan
Subject: Re: Request for Comments: PLT2020-00018; JRJK Dream Acres Major Subdivision Final Plat
Date: Thursday, May 21, 2020 10:46:25 AM
Attachments: image003.png

Good morning Layla,

Thank you for your request. It looks as if it is entirely in Adams 12, so we would have no objection either.

Kerrie Monti
Planning Manager

1850 Egbert Street, Suite 140, Brighton, CO 80601
T 303.655.2984 F 303.655.2805
kmonti@sd27j.net
www.sd27j.org

On Wed, May 20, 2020 at 11:21 AM Layla Bajelan <LBajelan@adcogov.org> wrote:

> # Request for Comments
>
> Case Name: JRJK Dream Acres Major Subdivision- Final Plat
>
> Case Number: PLT2020-00018

From: Loeffler - CDOT, Steven
To: Layla Bajelan
Subject: PLT2020-00018, JRJK Dream Acres Major Subdivision - Final Plat
Date: Friday, May 29, 2020 8:20:26 AM

Layla,

I have reviewed the request for comments for a Major Subdivision - Final Plat to create three lots from three existing parcels located at 13830 Franklin Street and have no objections.

Thank you for the opportunity to review this referral.

Steve Loeffler
Permits Unit- Region 1

P 303.757.9891 | F 303.757.9886
2829 W. Howard Pl. 2nd Floor, Denver, CO 80204
steven.loeffler@state.co.us | www.codot.gov | www.cotrip.org

COLORADO
Division of Water Resources
Department of Natural Resources

July 7, 2020

Layla Bajelan
Adams County Community & Economic Development Department
Transmitted via email: LBajelan@adcogov.org

Re: Wadley Farms Subdivision (aka JRJK Dream Acres) Final Plat
Case PRC2020-00018
Section 23, Township 1 South, Range 68 West, 6th P.M.
Water Division 1, Water District 2

Dear Ms. Bajelan:

This letter is to inform you that as required by our December 18, 2019 comment letter, on June 29, 2020 and July 1, 2020, the Applicant submitted well permit applications to the State Engineer's Office to re-permit well nos. 194697 and 199898, in accordance with the Water Supply Plan for Wadley Farms Subdivision (aka JRJK Dream Acres) subdivision for the new Lots 1 and 2. The new permits will be issued once the final plat for Wadley Farms Subdivision (aka JRJK Dream Acres) is approved by the county and a copy of the approval is submitted to the State Engineers Office.

Should you or the Applicant have any questions, please contact Ioana Comaniciu of this office at 303-866-3581 ext. 8246.

Sincerely,

Joanna Williams, P.E.
Water Resource Engineer

Ec: Subdivision File 25661
File for permit nos. 194697 and 199898
Applicant-Mr. James Hill

COLORADO
Division of Water Resources
Department of Natural Resources

May 26, 2020

Layla Bajelan
Adams County Community & Economic Development Department
Transmitted via email: LBajelan@adcogov.org

Re: Wadley Farms Subdivision (aka JRJK Dream Acres) Final Plat
Case PRC2020-00018
Section 23, Township 1 South, Range 68 West, 6th P.M.
Water Division 1, Water District 2

Dear Ms. Bajelan:

We have reviewed your referral dated May 20, 2020 regarding the above-referenced request to subdivide approximately 40 acres, comprised of Lots 1 and 2, Beninati Subdivision and a 35 acre tract, into three residential lots of approximately 27.614 acres (Lot 1), 7.332 acres (Lot 2) and 5.428 acres (Lot 3). Two existing wells operated under permit nos. 194697 and 199898 are located on Lot 1 and Lot 2 respectively, of Beninati Subdivision. The State Engineer's Office previously provided comments to the Wadley Farms Subdivision (aka JRJK Dream Acres), by our letters dated January 25, 2019 and October 17, 2019 and December 18, 2019.

The comments from our previous letter dated December 18, 2019 (copy enclosed) regarding the water supply for this subdivision still apply, however as identified in the December 18, 2019 letter, **the Applicant was required to submit well permit applications to the State Engineer's Office to re-permit well nos. 194697 and 199898 prior to subdivision approval. Since well permit applications were not submitted as required by our December 18, 2019 letter, we cannot recommend approval of the final plat for the Wadley Farms Subdivision (aka JRJK Dream Acres) until the Applicant applies to re-permit well nos. 194697 and 199898 in accordance with the Water Supply Plan for this subdivision for the new Lots 1 and 2. In addition, if this requirement is not met, a well permit for a future well on Lot 3 cannot be issued. As previously requested those well permit applications should include a copy of the December 18, 2019 letter.**

Should you or the Applicant have any questions, please contact Ioana Comaniciu of this office at 303-866-3581 ext. 8246.

Sincerely,

Joanna Williams, P.E.
Water Resource Engineer

Ec: Subdivision File 25661
File for permit nos. 194697 and 199898
Applicant-Mr. James Hill

COLORADO
Division of Water Resources
Department of Natural Resources

December 18, 2019

Layla Bajelan
Adams County Community & Economic Development Department
Transmitted via email: LBajelan@adcogov.org

Re: Wadley Farms Subdivision (aka JRJK Dream Acres)
Case PRC2018-00025
Section 23, Township 1 South, Range 68 West, 6th P.M.
Water Division 1, Water District 2

Dear Ms. Bajelan:

We have reviewed your referral dated December 17, 2019 regarding the above-referenced request to subdivide approximately 40 acres, comprised of Lots 1 and 2, Beninati Subdivision and a 35 acre tract, into three residential lots of approximately 27.614 acres (Lot 1), 7.332 acres (Lot 2) and 5.428 acres (Lot 3). Lot 2 of Beninati Subdivision will be incorporated into Lot 1 of Wadley Farms Subdivision and Lot 1 of Beninati Subdivision will be incorporated into Lot 2 of Wadley Farms Subdivision. The application is also requesting to change the zoning of the 35 acre tract from A-3 to A-1. Two existing wells operated under permit nos. 194697 and 199898 are located on Lot 1 and Lot 2 respectively, of Beninati Subdivision. The State Engineer's Office previously provided comments to the Wadley Farms Subdivision, by our letters dated January 25, 2019 and October 17, 2019.

Water Supply Demand

The estimated water demand for the new Lot 1 (27.617 acres) is 1.61 acre-feet/year. The ground water will be used inside one single family dwelling, irrigation of up to 15,000 square-feet of lawn and garden and the watering of not more than 20 large noncommercial domestic animals.

The estimated water demand for the new Lot 2 (7.332 acres) is 0.697 acre-feet/year. The ground water will be used inside one single family dwelling, irrigation of up to 5,800 square-feet of lawn and garden and the watering of not more than 8 large noncommercial domestic animals.

The estimated water requirement for the new Lot 3 (5.428 acres) is 0.517 acre-feet, for use inside one single family dwelling, irrigation of not more than 3,300 square-feet of lawn and garden and the watering of four large noncommercial domestic animals.

Water Supply Source

According to a Water Supply Plan provided the existing well, permit no. 199898, will be used to supply the new Lot 1 (27.617 acres) and the existing well, permit no. 194697, will be used to supply the new Lot 2 (7.332 acres). Both wells were constructed into the nontributary Laramie-Fox Hills aquifer. Further the Water Supply Plan indicates that Lot 3 (5.428 acres) will be supplied by a new well to be constructed into the nontributary Laramie-fox Hills aquifer. The Applicant proposes to re-permit the existing well permit nos. 199898 and 194697 for the newly created lots.

In our previous letter from January 25, 2019 we indicated that based on the Denver Basin Rules and site specific information the amounts of water available in the Laramie-Fox Hills aquifer underlying the 27.614 acres (Lot 1), 7.332 acres (Lot 2) and 5.428 acres (Lot 3), are as shown in Table 1 below.

Table 1

Aquifer	Lot 1 Assuming 100 Year Aquifer Allocation (acre-feet)	Lot 2 Assuming 100 Year Aquifer Allocation (acre-feet)	Lot 3 Assuming 100 Year Aquifer Allocation (acre-feet)	Approximate Aquifer Depth	Type
Laramie-Fox Hills	7.87	2.09	1.55	800-1095	NT

NT=Nontributary

We also mentioned that, unless the water underlying the property is decreed in water court, well permits would ultimately be issued pursuant to C.R.S. 37-92-602(3)(b)(I) and the policy of the State Engineer. Under those provisions only the quantity of water underlying the individual lots could be considered available for withdrawal by the existing wells and proposed well. To the extent that the parcel sizes change from those currently proposed the amount of water available to the lots will also change.

The proposed source of water for this subdivision is a bedrock aquifer in the Denver Basin. The State Engineer's Office does not have evidence regarding the length of time for which Laramie-Fox Hills aquifer will be a physically and economically viable source of water. According to 37-90-137(4)(b)(I), C.R.S., "Permits issued pursuant to this subsection (4) shall allow withdrawals on the basis of an aquifer life of one hundred years." Based on this **allocation** approach, the annual amounts of water shown in Table 1 are equal to one percent of the total amount, as determined by rules 8.A and 8.B of the Statewide Nontributary Ground Water Rules, 2 CCR 402-7. Therefore, the water may be withdrawn in those annual amounts for a maximum of 100 years.

In the Adams *County Development Standards and Regulations*, Effective April 15, 2002, Section 5-04-05-06-04 states:

> "Prior to platting, the developer shall demonstrate that…the water supply is dependable in quantity and quality based on a minimum useful life of three-hundred (300) years. A minimum 300-year useful life means the water supply from both a static and dynamic basis will be viable for a minimum 300-year period. The static analysis shall include evaluation of the volume of water that is appropriable for the proposed subdivision. The dynamic analysis shall evaluate whether the appropriable water supply is sustainable for three-hundred (300) years, giving consideration to the location and extent of the aquifer, as well as impacts caused by both current and future pumping by others from the aquifer."

The State Engineer's Office does not have evidence regarding the length of time for which this source will be "dependable in quantity and quality." However, treating Adams County' s requirement as an **allocation** approach based on three hundred years, the allowed average annual amount of withdrawal from the Laramie-Fox Hills aquifer shown in Table 1 above would be reduced to one third of those amounts as shown in Table 2 below:

Table 2

Aquifer	Lot 1 Assuming 300 Year Aquifer Life (acre-feet)	Lot 2 Assuming 300 Year Aquifer Life (acre-feet)	Lot 3 Assuming 300 Year Aquifer Life (acre-feet)
Laramie-Fox Hills	2.62	0.697	0.517

The estimated water demand for the new lots are within the limitation of the amount of water available underlying each individual lot listed in Table 2 above. However, the amounts available and allowed uses could change if the lots sizes vary from those specified in this letter.

State Engineer's Office Opinion

Based upon the above and pursuant to Section 30-28-136(1)(h)(II), C.R.S., it is our opinion that the proposed revised water supply will be adequate and can be provided without causing injury to decreed water rights, provided well permit nos. 194697 and 199898 are re-permitted in accordance with the Water Supply Plan for this subdivision as soon as the subdivision is approved. To assure that the wells are re-permitted upon subdivision approval the Applicant should submit well permit applications to the State Engineer's Office to re-permit well nos. 194697 and 199898 prior to subdivision approval. Those well permit applications should include a copy of this letter.

Our opinion that the water supply is **adequate** is based on our determination that the amount of water required annually to serve the subdivision is currently physically available, based on current estimated aquifer conditions.

Our opinion that the water supply can be **provided without causing injury** is based on our determination that the amount of water that is legally available on an annual basis, according to the statutory **allocation** approach, for the proposed uses is greater than the annual amount of water required to supply existing water commitments and the demands of the proposed subdivision.

Our opinion is qualified by the following:

The amounts of water in the Denver Basin aquifers, and identified in this letter, are calculated based on estimated current aquifer conditions. For planning purposes the county should be aware that the economic life of a water supply based on wells in a given Denver Basin aquifer may be less than the 300 years used for allocation due to anticipated water level declines. We recommend that the county determine whether it is appropriate to require development of renewable water resources for this subdivision to provide for a long-term water supply.

Should you or the Applicant have any questions, please contact Ioana Comaniciu of this office at 303-866-3581 ext. 8246.

Sincerely,

Joanna Williams, P.E.
Water Resource Engineer

Ec: Subdivision File 25661
File for permit nos. 194697 and 199898
Applicant-Mr. James Hill

From: Woodruff, Clayton
To: Layla Bajelan
Subject: PLT 2020-00018
Date: Monday, June 08, 2020 11:31:05 AM

Layla,

The RTD has no comments regarding the plat of this project we would like to see the plans for the development after the replat.

thank you

C. Scott Woodruff
Engineer III
Regional Transportation District
1560 Broadway, Suite 700, FAS-73 | Denver, CO 80202

o 303.299.2943 | m 303-720-2025
clayton.woodruff@rtd-denver.com

From:	Dan Biro
To:	Layla Bajelan
Subject:	RE: Request for Comments: PLT2020-00018; JRJK Dream Acres Major Subdivision Final Plat
Date:	Thursday, May 21, 2020 3:18:25 PM
Attachments:	image001.png image002.png image006.png image016.png image017.png

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No comments on this review.

Dan Biro, P.E.
DEPUTY FIRE MARSHAL
Thornton Fire Department
Main: 303-538-7602
Office: 303-538-7663
Fax: 303-538-7660
dan.biro@ThorntonCO.gov
gocot.net/fire
City of Thornton

From: Laurie Davidson <Laurie.Davidson@thorntonco.gov>
Sent: Wednesday, May 20, 2020 11:47 AM
To: Stephanie Harpring <Stephanie.Harpring@thorntonco.gov>; Dan Biro <Dan.Biro@thorntonco.gov>
Subject: FW: Request for Comments: PLT2020-00018; JRJK Dream Acres Major Subdivision Final Plat

---

From: Layla Bajelan <LBajelan@adcogov.org>
Sent: Wednesday, May 20, 2020 11:21 AM
To: Layla Bajelan <LBajelan@adcogov.org>
Subject: [EXTERNAL] Request for Comments: PLT2020-00018; JRJK Dream Acres Major Subdivision Final Plat

Request for Comments

Case Name:	JRJK Dream Acres Major Subdivision- Final Plat
Case Number:	PLT2020-00018

May 20, 2020

Right of Way & Permits
1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303.571.3284
donna.l.george@xcelenergy.com

June 10, 2020

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Layla Bajelan

Re: JRJK Dream Acres Major Subdivision Final Plat, Case # PLT2020-00018

Public Service Company of Colorado's (PSCo) Right of Way & Permits Referral Desk has reviewed the plat for **JRJK Dream Acres** and has **no apparent conflict**.

The property owner/developer/contractor must complete the application process for any new natural gas or electric service via xcelenergy.com/InstallAndConnect. It is then the responsibility of the developer to contact the Designer assigned to the project for approval of design details. Additional easements may need to be acquired by separate document for new facilities.

As a safety precaution, PSCo would like to remind the developer to call the Utility Notification Center by dialing 811 for utility locates prior to construction.

Donna George
Right of Way and Permits
Public Service Company of Colorado dba Xcel Energy
Office: 303-571-3306 – Email: donna.l.george@xcelenergy.com

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Request for Comments

Case Name: JRJK Dream Acres Major Subdivision-Final Plat

Case Number: PLT2020-00018

May 20, 2020

The Adams County Planning Commission is requesting comments on the following application: **Major Subdivision- Final Plat to create three lots from three existing parcels.** This request is located at 13830 Franklin St. The Assessor's Parcel Numbers are: 0157323000010, 0157323002018, 0157323002019.

Applicant Information: James and Kathleena Hill
13830 Franklin St
Brighton, CO 80602

Please forward any written comments on this application to the Community and Economic Development Department at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216 or call (720) 523-6800 by 06/11/2020 in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to LBajelan@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional colored maps can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Layla Bajelan

Layla Bajelan, Long Range Planner II
Case Manager

Referral Listing
Case Number PLT2020-00018
JRJK Dream Acres Major Subdivision-Final Plat

Agency	Contact Information
ADAMS 12 FIVE STAR SCHOOLS	MATT SCHAEFER - PLANNING MANAGER 1500 E. 128TH AVENUE THORNTON CO 80241 720-972-4289 matt.schaefer@adams12.org
Adams County Attorney's Office	Christine Fitch 4430 S Adams County Pkwy Brighton CO 80601 720-523-6352 CFitch@adcogov.org
Adams County CEDD Addressing	Mark Alessi PLN 720.523.6837 malessi@adcogov.org
Adams County CEDD Development Services Engineer	Devt. Services Engineering 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6800
Adams County CEDD Right-of-Way	Mark Alessi 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6837 malessi@adcogov.org
Adams County Community & Economic Development Department	Gina Maldonado 4430 S. Adams County Pkwy Brighton CO 80601 720-523-6823 gmaldonado@adcogov.org
Adams County Community Safety & Wellbeing, Neighborhood Services	Gail Moon 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6856 gmoon@adcogov.org
Adams County Construction Inspection	Gordon .Stevens 4430 S. Adams County Pkwy Brighton CO 80601 720-523-6965 gstevens@adcogov.org

Agency	Contact Information
Adams County Development Services - Building	Justin Blair 4430 S Adams County Pkwy Brighton CO 80601 720-523-6825 JBlair@adcogov.org
Adams County Parks and Open Space Department	Aaron Clark (303) 637-8005 aclark@adcogov.org
Adams County Parks and Open Space Department	Marc Pedrucci 303-637-8014 mpedrucci@adcogov.org
Adams County Sheriff's Office	Rick Reigenborn (303) 654-1850 rreigenborn@adcogov.org
Adams County Sheriff's Office	- - 303-655-3283 CommunityConnections@adcogov.org
Adams County Treasurer	Lisa Culpepper 4430 S. Adams County Pkwy. Brighton CO 80601 720.523.6166 lculpepper@adcogov.org
AMBER CREEK METROPOLITAN DISTRICT	BARBARA VANDER 7400 E ORCHARD RD, SUITE 3300 GREENWOOD VILLAGE CO 80111 303 770-2700
BRIGHTON SCHOOL DISTRICT 27J	Kerrie Monti 1850 EGBERT STREET SUITE 140, BOX 6 BRIGHTON CO 80601 303-655-2984 kmonti@sd27j.net
Century Link, Inc	Brandyn Wiedreich 5325 Zuni St, Rm 728 Denver CO 80221 720-578-3724 720-245-0029 brandyn.wiedrich@centurylink.com
CITY OF NORTHGLENN	Brook Svoboda 11701 COMMUNITY CENTER DRIVE NORTHGLENN CO 80233-8061 303-450-8937 bsvoboda@northglenn.org
CITY OF THORNTON	JASON O'SHEA 9500 CIVIC CENTER DR THORNTON CO 80229 0

Agency	Contact Information
CITY OF THORNTON	Lori Hight 9500 CIVIC CENTER DRIVE THORNTON CO 80229 303-538-7670 developmentsubmittals@cityofthornton.net.
CITY OF THORNTON	JIM KAISER 12450 N WASHINGTON THORNTON CO 80241 720-977-6266
CITY OF WESTMINSTER	Andy Walsh 4800 W 92nd Avenue WESTMINSTER CO 80031 303-658-2563 awalsh@cityofwestminster.us
CITY OF WESTMINSTER	Rita McConnell 4800 W 92ND AVE. WESTMINSTER CO 80031 303-658-2093 rmcconne@cityofwestminster.us
COLO DIV OF WATER RESOURCES	Joanna Williams OFFICE OF STATE ENGINEER 1313 SHERMAN ST., ROOM 818 DENVER CO 80203 303-866-3581 joanna.williams@state.co.us
COLORADO DEPT OF TRANSPORTATION	Steve Loeffler 2000 S. Holly St. Region 1 Denver CO 80222 303-757-9891 steven.loeffler@state.co.us
COLORADO DIVISION OF WILDLIFE	Serena Rocksund 6060 BROADWAY DENVER CO 80216 3039471798 serena.rocksund@state.co.us
COLORADO DIVISION OF WILDLIFE	Matt Martinez 6060 BROADWAY DENVER CO 80216-1000 303-291-7526 matt.martinez@state.co.us
COLORADO GEOLOGICAL SURVEY	Jill Carlson 1500 Illinois Street Golden CO 80401 303-384-2643 303-384-2655 CGS_LUR@mines.edu
Colorado Geological Survey: CGS_LUR@mines.edu	Jill Carlson Mail CHECK to Jill Carlson 303-384-2643 303-384-2655 CGS_LUR@mines.edu

Agency	Contact Information
COMCAST	JOE LOWE 8490 N UMITILLA ST FEDERAL HEIGHTS CO 80260 303-603-5039 thomas_lowe@cable.comcast.com
METRO WASTEWATER RECLAMATION	CRAIG SIMMONDS 6450 YORK ST. DENVER CO 80229 303-286-3338 CSIMMONDS@MWRD.DST.CO.US
NORTH METRO FIRE DISTRICT	Steve Gosselin 101 Lamar Street Broomfield CO 80020 (303) 452-9910 sgosselin@northmetrofire.org
NS - Code Compliance	Caleb Bachelor 4430 S. Adams County Pkwy Brighton CO 80601 720.523.6206 cbachelor@adcogov.org
NS - Code Compliance	Joaquin Flores 720.523.6207 jflores@adcogov.org
REGIONAL TRANSPORTATION DIST.	Engineering RTD 1560 BROADWAY SUITE 700 DENVER CO 80202 303-299-2439 engineering@rtd-denver.com
THORNTON FIRE DEPARTMENT	Chad Mccollum 9500 Civic Center Drive THORNTON CO 80229-4326 303-538-7602 firedept@cityofthornton.net
UNION PACIFIC RAILROAD	Anna Dancer 1400 DOUGLAS ST STOP 1690 OMAHA NE 68179 402-544-2255 aldancer@up.com
United Power	- - 303-659-0551 platreferral@unitedpower.com
United States Postal Service	Jason Eddleman 303-853-6025 Jason.G.Eddleman@usps.gov
United States Postal Service	Arlene Vickrey 303-853-6644 Arlene.A.Vickrey@usps.gov

Agency	Contact Information
WADLEY FARMS HOA	Bob Olivier PO BOX 1208 EASTLAKE CO 80614 303.457.9789 303.550.9682 wadleyfarmshoa@msn.com
WESTMINSTER FIRE DEPT.	CAPTAIN DOUG HALL 9110 YATES ST. WESTMINSTER CO 80031 303-430-2400 x4542 dhall@ci.westminster.co.us
WRIGHT FARMS METRO DISTRICT	KIM J. SETER, ESQ 7400 E ORCHARD RD STE 3300 GREENWOOD VILLAGE CO 80111 303-770-2700 svw@svwpc.com
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com

FLORA ASSOCIATES
C/O RUSSELL N WATTERSON
13821 GAYLORD ST
BRIGHTON CO 80602

MAHON R DAVID AND
MAHON NILSA GUERREO
13839 FRANKLIN ST
BRIGHTON CO 80602

MOUNTAIN VIEW AT WADLEY FARMS LLC
13830 FRANKLIN ST
BRIGHTON CO 80602-6358

OLIVER ROBERT D
13748 DOWNING ST
BRIGHTON CO 80602

SMITH JOHN R AND
SMITH BARBARA L
13838 DOWNING ST
BRIGHTON CO 80602-6346

STEELE SHERRIE
PO BOX 424
EASTLAKE CO 80614-0424

ABBOTT BRANDYN
OR CURRENT RESIDENT
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BAUER LARRY A AND
BAUER JENNY A
OR CURRENT RESIDENT
13989 FRANKLIN STREET
BRIGHTON CO 80602-6397

BAXTER AARON
OR CURRENT RESIDENT
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BEATTIE LYAL STORM III AND
BEATTIE LAURIE A
OR CURRENT RESIDENT
1981 E 138TH AVE
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CHIGRO JEFFREY L
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DEINES MARNA L
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13731 FRANKLIN ST
BRIGHTON CO 80602-6360

DICKERT ANDREAS
OR CURRENT RESIDENT
13680 FRANKLIN ST
BRIGHTON CO 80602

EATHERTON DAVID S AND SHERALYN
OR CURRENT RESIDENT
13729 FRANKLIN ST
BRIGHTON CO 80602

HERZ CHRISTINA AND
HERZ LINDA AND HERZ STEVEN
OR CURRENT RESIDENT
13901 FRANKLIN ST
BRIGHTON CO 80602-6357

HILL JAMES J AND
HILL KATHLEENA
OR CURRENT RESIDENT
13830 FRANKLIN ST
BRIGHTON CO 80602

KOWALSKY JAMES B AND
KOWALSKY JACQUELINE CAHILL
OR CURRENT RESIDENT
13969 FRANKLIN ST
BRIGHTON CO 80602

KRESNIK ANGELA MICHELLE
KRESNIK MICHAEL TODD
OR CURRENT RESIDENT
13939 FRANKLIN ST
BRIGHTON CO 80602-6357

MAHON R DAVID AND
MAHON NILSA GUERRERO
OR CURRENT RESIDENT
13839 FRANKLIN ST
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MUDD MARY DIANE
OR CURRENT RESIDENT
13687 RACE CT
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NELSON RHONDA
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13850 FRANKLIN ST
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NICHOLS GEORGE J III
OR CURRENT RESIDENT
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NYHOLM STEWART E AND
NYHOLM CHRISTINE M
OR CURRENT RESIDENT
13789 FRANKLIN STREET
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OLIVIER ROBERT D
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13748 DOWNING ST
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PATTERSON GARY STEVEN AND
PATTERSON RICHELLE RENEE
OR CURRENT RESIDENT
13788 DOWNING STREET
BRIGHTON CO 80601

PHILLIPS CLAYTON AND PHILLIPS MICHELLE AND
SUMNER JOHN JR AND SUMNER SHIRLEY
OR CURRENT RESIDENT
13639 FRANKLIN ST
BRIGHTON CO 80602-6355

PRONTO JEFFREY L AND
PRONTO REBECCA S
OR CURRENT RESIDENT
13881 GAYLORD ST
BRIGHTON CO 80602-6367

PROPST DIANA L
OR CURRENT RESIDENT
13699 FRANKLIN ST
BRIGHTON CO 80602

RIDDLE LORETTA M AND
RIDDLE TIMOTHY J
OR CURRENT RESIDENT
1751 E 136TH AVE
BRIGHTON CO 80602

ROMERO ROXANNE AND
MELENDEZ VINCENT
OR CURRENT RESIDENT
13750 FRANKLIN ST
BRIGHTON CO 80602-6356

ROSALES PETE A AND
ROSALES JOAN M
OR CURRENT RESIDENT
1851 E 138TH AVE
BRIGHTON CO 80602

ROSENDAHL JAMIE M/JAMES J AND
HILL KATHLEENA M
OR CURRENT RESIDENT
13878 DOWNING ST
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SASSANO THERESA AND
KENNEDY RICHARD S
OR CURRENT RESIDENT
13727 RACE CT
BRIGHTON CO 80602-6377

SILVA FELIPE DE JESUS SANCHEZ
OR CURRENT RESIDENT
13938 DOWNING ST
BRIGHTON CO 80602-6348

SMITH JOHN ROY AND SMITH BARBARA LYNNE
THE JOHN R. SMITH & BARBARA L. SMITH TRUST
OR CURRENT RESIDENT
13838 DOWNING ST
BRIGHTON CO 80602-6346

THIERSCH JOHN A AND
THIERSCH ELIZABETH D
OR CURRENT RESIDENT
13968 DOWNING ST
BRIGHTON CO 80602-6348

THORP JOYCE A AND
KRATZER TARA A
OR CURRENT RESIDENT
1830 E 138TH AVE
BRIGHTON CO 80602-6302

TRAN NGHI VAN AND
BUI THI THU
OR CURRENT RESIDENT
1619 E 136TH AVE
BRIGHTON CO 80602-7720

TURNER RICKEY A AND
TURNER YVONNE E
OR CURRENT RESIDENT
13921 GAYLORD ST
BRIGHTON CO 80602

CURRENT RESIDENT
13821 GAYLORD ST
BRIGHTON CO 80602-6367

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Subdivision Improvement Agreement for Ridgeview Estates Final Plat, Filing No. 1
FROM: Jill Jennings Golich, Director
AGENCY/DEPARTMENT: Community and Economic Development Department
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the Subdivision Improvement Agreement for Ridgeview Estates, Filing No. 1, Case No. SIA2019-00019.

BACKGROUND:

On August 13, 2019, the Board of County Commissioners approved a major subdivision preliminary plat for Ridgeview Estates to create 21 lots on approximately 62.3 acres. The subject application is for Filing, No. 1 and consists of 11 of the 21 lots.

David Moore, on behalf of Alliance Development Services, is requesting a major subdivision final plat for the Ridgeview Estates Subdivision, Filing No. 1. The final plat for Filing No. 1 consists of 11 single-family residential lots, two non-residential tracts, and associated public streets.

The subject Subdivision Improvements Agreement (SIA) allows for the Developer to enter into a written agreement with the County to install public and/or private improvements, and to deed land for public purposes or right-of-way or submit cash-in-lieu.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community and Economic Development
County Attorney

ATTACHED DOCUMENTS:

Resolution Approving Application in Case #SIA2019-00019
Subdivision Improvement Agreement
Exhibit B of the Subdivision Improvement Agreement

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION APPROVING CASE #SIA2019-00019 SUBDIVISION IMPROVEMENTS AGREEMENT FOR RIDGEVIEW ESTATES, FILING NO. 1

WHEREAS, it is provided by resolution of the Board of County Commissioners, County of Adams, that where designated the Developer shall have entered into a written agreement with the County to install public and/or private improvements, and to deed land for public purposes or right-of-way or submit cash-in-lieu; and,

WHEREAS, on September 1st, 2020, the Board of County Commissioners, in Case No. PLT2019-00026, Ridgeview Estates, Filing No. 1, approved a Final Plat to allow 11 residential lots and 2 non-residential tracts on approximately 36 acres in the Residential Estate (RE) zone district; and,

WHEREAS, the Developer will provide collateral to meet the terms of the agreement prior to the issuance of any permit within the subdivision; and,

WHEREAS, the Adams County Community and Economic Development Department recommends approval of the attached Subdivision Improvements Agreement for Ridgeview Estates, Filing No. 1 , Case No. SIA2019-00019.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Subdivision Improvements Agreement for Ridgeview Estates Filing No. 1, a copy of which is attached hereto and incorporated herein by this reference, be approved.

BE IT FURTHER RESOLVED that the Chair of the Board of County Commissioners be authorized to execute this AGREEMENT on behalf of the County of Adams, State of Colorado.

RIDGEVIEW ESTATES
SUBDIVISION
Case No. PLT2019-00026

SUBDIVISION IMPROVEMENTS AGREEMENT

THIS AGREEMENT is made and entered into by and between the County of Adams, State of Colorado, hereinafter called "County," and Ridgeview Properties LLC, 5540 Ward Road Suite 230 Arvada, CO 80002, hereinafter called "Developer."

WITNESSETH:

WHEREAS, Developer is the owner of real property in the County of Adams, State of Colorado, as described in Exhibit "A" attached hereto, and by this reference made a part hereof.

WHEREAS, it is provided by resolution of the Board of County Commissioners, County of Adams, that where designated the Developer shall have entered into a written agreement with the County to install public and/or private improvements, and to deed land for public purposes or right-of-way.

NOW, THEREFORE, in consideration of the foregoing, the parties hereto promise, covenant, and agree as follows:

1. **Engineering Services**. Developer shall furnish, at its own expense, all engineering and other services in connection with the design and construction of the improvements described and detailed on Exhibit "B" attached hereto, and by this reference made a part hereof.

2. **Drawings and Estimates**. The Developer shall furnish drawings and cost estimates for all improvements described and detailed on Exhibit "B" for approval by the County. Upon request, the Developer shall furnish one set of reproducible "as built" drawings and a final statement of construction costs to the County.

3. **Construction**. Developer shall furnish and construct, at its own expense and in accordance with drawings and materials approved by the County, the improvements described and detailed on Exhibit "B".

4. **Time for Completion**. Improvements shall be completed according to the terms of this agreement within "construction completion date" appearing in Exhibit "B". The Director of Community and Economic Development Department may for good cause grant extension of time for completion of any part or all of improvements appearing on said Exhibit "B". Any extension greater than 180 days is within the sole discretion of the Board of County Commissioners. All extensions of time must be in writing.

5. **Guarantee of Compliance**. Developer shall furnish to the County a cash escrow deposit or other acceptable collateral, releasable only by the County, to guarantee compliance with this agreement. Said collateral shall be in the amount of $751,334 including twenty percent (20%) to cover administration and five percent (5%) per year for the term of the Agreement to cover inflation. Upon approval of the final plat, completion of said improvements constructed according to the terms of this agreement, and preliminary acceptance by the Director of Public Works in accordance with section 5-02-05-01 of the County's Development Standards and Regulations, the collateral shall be released. Completion of said improvements shall be determined solely by the County, and a reasonable part of said collateral, up to 20%, may be retained to guarantee maintenance of public improvements for a period of one year from the date of Preliminary Acceptance.

   No building permits shall be issued until said collateral is furnished in the amount required and in a form acceptable to the Board of County Commissioners, and until the final plat has been approved and the improvements described in Exhibit "B" have been preliminarily accepted by the Department of Public Works.

6. **Acceptance and Maintenance of Public Improvements**. All improvements designated "public" on Exhibit "B" shall be public facilities and become the property of the County or other public agencies upon acceptance. During the period of one year from and after the acceptance of public improvements, the Developer shall, at its own expense, make all needed repairs or replacement due to defective materials or workmanship which, in the opinion of the County, becomes necessary. If, within ten days of written notice to the Developer from the

County requesting such repairs or replacements, the Developer has not undertaken with due diligence to make the same, the County may make such repairs or replacements at the Developer's expense. In the case of an emergency such written notice may be waived.

7. **Successors and Assigns**. This agreement shall be binding upon the heirs, executors, personal representatives, successors, and assigns of the Developer, and shall be deemed a covenant running with the real property as described in Exhibit "A" attached hereto.

8. **Improvements and Dedication**. The undersigned Developer hereby agrees to provide the following improvements, and to dedicate described property.

A. **Improvements**.

Public Improvements:

Earthwork, sediment and erosion control, storm drainage, public road construction, dry utilities, surveying, engineering, testing and construction management (See Exhibit "B" for description, estimated quantities and estimated construction costs.)

Private Improvement: Driveway construction on 27910 E160th Avenue as shown on drawing C9 and included in Guarantee of Compliance.

The improvements shall be constructed in accordance with all County requirements and specifications in accordance with the approved plans and time schedule as indicated in Exhibit "B".

B. **Public dedication of land for right-of-way purposes or other public purpose**. Upon approval of this agreement by the Board of County Commissioners, the Developer hereby agrees to convey by warranty deed to the County of Adams the following described land for right-of-way or other public purposes:

Road right of ways consisting of East 159th Avenue, Deer Park Street and East 158th Place.

[SIGNATURE PAGES TO FOLLOW]

Ridgeview Properties LLC
5440 Ward Road Suite 230
Arvada, CO 80002
720-907-9778

By: _____
Chad Ochsner
Ridgeview Properties LLC, Manager

By: _____
David Moore
Ridgeview Properties LLC, Manager

The foregoing instrument was acknowledged before me this _____ day of _____, 2020, by _____.

My commission expires:_____

Address: _____
_____

_____
Notary Public

APPROVED BY resolution at the meeting of _____, 2020.

Collateral to guarantee compliance with this agreement and construction of public improvements shall be required in the amount of $751,334. No building permits shall be issued until said collateral is furnished in the amount required and in a form acceptable to the Board of County Commissioners and until the improvements described in Exhibit "B" have been preliminarily accepted.

ATTEST:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____
Clerk of the Board

_____
Chair

EXHIBIT A

Legal Description:

LEGAL DESCRIPTION

KNOW ALL MEN BY THESE PRESENTS, THAT RIDGEVIEW ESTATE LLC, A COLORADO CORPORATION, BEING THE OWNER OF A PORTION OF THE WEST HALF OF SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:
BEGINNING AT THE NORTHEAST CORNER OF THE NORTHWEST QUARTER OF SAID SECTION 10, TOWNSHIP 1 SOUTH, RANGE 65 WEST OF THE 6TH P.M., THENCE S 00°05'13" E ALONG THE EAST LINE OF THE WEST HALF OF SECTION 10, WITH ALL BEARINGS CONTAINED HEREON RELATIVE THERETO, A DISTANCE OF 1495.68 FEET;
THENCE DEPARTING SAID EAST LINE OF THE WEST HALF OF SECTION 10, N 76°50'50" W, A DISTANCE OF 903.48 FEET;
THENCE N 69°27'56" W A DISTANCE OF 596.98 FEET;
THENCE N 60°05'53" W A DISTANCE OF 537.87 FEET;
THENCE N 39°37'58" W A DISTANCE OF 507.03 FEET;
THENCE N 17°26'04" W A DISTANCE OF 38.65 FEET;
THENCE N 90°00'00" W A DISTANCE OF 406.46 FEET, TO A POINT ON THE EAST LINE OF THE NORTHEAST QUARTER OF SECTION 9;
THENCE ALONG SAID EAST LINE OF THE NORTHEAST QUARTER OF SAID SECTION 9, N 00°07'50" W A DISTANCE OF 373.61 FEET, TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND DESCRIBED IN BOOK 4431 PAGE 18, COUNTY PUBLIC RECORDS;
THENCE ALONG THE SOUTH LINE OF SAID PARCEL, THE FOLLOWING TWO (2) COURSES:
1) S 89°23'03" E PARALLEL WITH AND 40.00 FEET SOUTH OF, BY PERPENDICULAR MEASUREMENT, THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10, A DISTANCE OF 257.32 FEET;
2) THENCE N 72°13'56" E A DISTANCE OF 126.83 FEET, TO A POINT ON THE NORTH LINE OF THE WEST HALF OF SAID SECTION 10;
THENCE ALONG SAID NORTH LINE OF THE WEST HALF OF SECTION 10, S 89°23'03" E, A DISTANCE OF 2267.15 FEET TO THE POINT OF BEGINNING;
CONTAINING AN AREA OF 2,713,709 SQUARE FEET OF 62.298 ACRES MORE OR LESS.

EXHIBIT B

Public Improvements: Street Name/s

Description	Est. Quantity	Est. Unit Cost	Est. Construct. Cost

See Ridgeview Estates Exhibit B Spreadsheet

Construction Completion Date: August 31, 2021

Initials or signature of Developer:_____

Ridgeview Properties LLC

RIDGEVIEW ESTATES EXHIBIT B

Date 6/9/2020

FILING 1

Completion Date 8-31-21	Qty	Unit	Unit Price	Total Cost	Admin Fee 20%	Yearly Fee 5%	TOTAL COST
ONSITE CONSTRUCTION - PREPARATION & EARTHWORK							
MOBILIZATION	1	LS	$1,500.00	$1,500	$300	$90	$1,890
REMOVAL OF FENCING	1	LS	$800.00	$800	$160	$48	$1,008
STRIPPING AND GRUBBING 4 INCHES	6200	CY	$1.75	$10,850	$2,170	$651	$13,671
BALANCE (OVERLOT) NET FILL GRADING	9970	CY	$2.00	$19,940	$3,988	$1,196	$25,124
EROSION CONTROL SILT FENCE	5500	LF	$1.50	$8,250	$1,650	$495	$10,395
RESPREAD TOPSOIL	3000	CY	$1.75	$5,250	$1,050	$315	$6,615
MISC SUBGRADE PREP, CLEANUP,& TRASH REM	1	LS	$1,500.00	$1,500	$300	$90	$1,890
TOTAL - ONSITE PREPARATION AND EARTHWORK				**$48,090**	**$9,618**	**$2,885**	**$60,593**
CONSTRUCTION - SEDIMENT AND EROSION CONTROL							
MOBILIZATION	1	LS	$1,000.00	$1,000	$200	$60	$1,260
SILT FENCE	4325	LF	$1.50	$6,488	$1,298	$389	$8,175
STABILIZED CONSTRUCTION ENTRANCE	1	LS	$2,101.00	$2,101	$420	$126	$2,647
EQUIPMENT STORAGE AREA	1	EA	$500.00	$500	$100	$30	$630
MATERIAL STORAGE AREA	1	EA	$500.00	$500	$100	$30	$630
EROSION LOG	1050	LF	$5.00	$5,250	$1,050	$315	$6,615
INLET PROTECTION	1	EA	$220.00	$220	$44	$13	$277
OUTLET PROTECTION	8	EA	$220.00	$1,760	$352	$106	$2,218
SEDIMENT BASIN	1	EA	$550.00	$550	$110	$33	$693
CONCRETE WASHOUT	1	EA	$671.00	$671	$134	$40	$845
TOTAL - SEDIMENT AND EROSION CONTROL				**$19,040**	**$3,808**	**$1,142**	**$23,990**
CONSTRUCTION - ONSITE STORM DRAINAGE							
18" RCP (OFFSITE DRIVEWAY)	44	LF	$100.00	$4,400	$880	$264	$5,544
18" END SECTION (OFFSITE DRIVEWAY)	2	EA	$563.00	$1,126	$225	$68	$1,419
24"RCP	227	LF	$120.00	$27,240	$5,448	$1,634	$34,322
24" END SECTION	7	EA	$650.00	$4,550	$910	$273	$5,733
36" RCP	79	LF	$220.00	$17,380	$3,476	$1,043	$21,899
19x30 RCP	145	LF	$220.00	$31,900	$6,380	$1,914	$40,194
24x38 RCP	174	LF	$240.00	$41,760	$8,352	$2,506	$52,618
24x38 END SECTION	2	LF	$850.00	$1,700	$340	$102	$2,142
TYPE 'D' OUTLET BOX W/ MICRO POOL	1	EA	$5,784.00	$5,784	$1,157	$347	$7,288

Completion Date 8-31-21	Qty	Unit	Unit Price	Total Cost	20%	5%	COST
CONCRETE OUTLET PIPE HEADWALLS	10	CY	$300.00	$3,000	$600	$180	$3,780
BURIED RIP RAP	300	TN	$40.00	$12,000	$2,400	$720	$15,120
RIPRAP	59	TN	$32.00	$1,888	$378	$113	$2,379
NATIVE SEED MIX - DISTURBED AREA AND DETENTION POND	13	AC	$900.00	$11,700	$2,340	$702	$14,742
TOTAL - ONSITE STORM DRAINAGE				**$164,428**	**$32,886**	**$9,866**	**$207,179**
CONSTRUCTION - ONSITE PAVING							
MOBILIZATON	1	LS	$2,500.00	$2,500	$500	$150	$3,150
STREET GRADING & PREP.	12708	SY	$2.60	$33,041	$6,608	$1,982	$41,631
4" CL 6 SUBGRADE BASE	1426	TN	$16.00	$22,816	$4,563	$1,369	$28,748
STREET PAVING 3" COURSE BASE	1361	TN	$55.00	$74,855	$14,971	$4,491	$94,317
6' SHOULDER ROAD BASE	1001	TN	$16.00	$16,016	$3,203	$961	$20,180
DRIVEWAY REALIGNMENT ROAD BASE (OFFSITE DRIVEWAY)	136	TN	$16.00	$2,176	$435	$131	$2,742
VALVE ADJUSTMENT	12	EA	$225.00	$2,700	$540	$162	$3,402
ACCESS ROADS	830	LF	$10.00	$8,300	$1,660	$498	$10,458
STREET SIGNS	4	EA	$400.00	$1,600	$320	$96	$2,016
TOP LIFT PAVING (in one year)	1361	TN	$55.00	$74,855	$14,971	$4,491	$94,317
TOTAL - ONSITE PAVING				**$238,859**	**$47,772**	**$14,332**	**$300,962**
ONSITE UTILITIES							
ELECTRICITY (P.S. CO.)	12	LS	$4,000.00	$48,000	$9,600	$2,880	$60,480
GAS (P.S. CO.)	12	LS	$665.00	$7,980	$1,596	$479	$10,055
TELEPHONE (U.S. WEST)	12	LS	$450.00	$5,400	$1,080	$324	$6,804
CONDUITS	1	LS	$5,000.00	$5,000	$1,000	$300	$6,300
TOTAL - ONSITE UTILITIES				**$66,380**	**$13,276**	**$3,983**	**$83,639**
ONSITE SPECIAL ITEMS AND FEES							
MONUMENT SIGN	1	EA	$3,500.00	$3,500	$700	$210	$4,410
SURVEYING	1	EA	$18,000.00	$18,000	$3,600	$1,080	$22,680
ENGIINEERING	1	EA	$12,000.00	$12,000	$2,400	$720	$15,120
TESTING	1	EA	$6,000.00	$6,000	$1,200	$360	$7,560
CONSTRUCTION MANAGEMENT	1	EA	$20,000.00	$20,000	$4,000	$1,200	$25,200
TOTAL - ONSITE SPECIAL ITEMS & FEES				**$59,500**	**$11,900**	$3,570	**$74,970**
TOTAL COSTS				**$596,297**	**$119,259**	**$35,778**	**$751,334**

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Resolution accepting of a Special Warranty Deed from Alfred J. Linnebur Flying J Services, Inc to Adams County for Right-of-Way Purposes. Dedication of portions of 38th Avenue & Krebs Rd.
FROM: Jill Jennings Golich, Director, Community & Economic Development Department
AGENCY/DEPARTMENT: Community & Economic Development
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves a resolution accepting a Special Warranty Deed from Alfred J. Linnebur Flying J Services to Adams County for Right-of Way Purposes.

BACKGROUND:
Adams County is being granted road right-of-way from Alfred J. Linnebur Flying J Services, Inc, on a property located at 64001 US Highway 36, Byers, CO 80103. The purpose of the dedication is part of a Land Survey Plat in which the landowner is granting the easterly sixty feet (60') of Section 30 and the northernly forty feet (40') to Adams County to allow the County to acquire ownership in additional right-of-way of E 38th Avenue and Krebs Road in order to comply with the future development.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Public Works
Office of the County Attorney

ATTACHED DOCUMENTS:
Warranty Deed
Planning Commission Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

Resolution 2020-

RESOLUTION ACCEPTING A SPECIAL WARRANTY DEED FROM ALFRED J. LINNEBUR FLYING SERVICE, INC, TO ADAMS COUNTY FOR RIGHT-OF-WAY DEDICATION PURPOSES

WHEREAS, the Planning Commission for Adams County, Colorado, has considered the advisability of accepting a Special Warranty Deed from Alfred J Linnebur Flying Service, Inc, for property located in the Part of Section 30, Township 3 South, Range 61 West of the 6th Principal Meridian as described in the attached easement agreement; and

WHEREAS, this Special Warranty Deed is in conjunction with a Land Survey Plat.

WHEREAS, at a regular meeting of the Planning Commission for Adams County, Colorado, held at the County Government Center in Brighton on Thursday the 9th day of July, 2020, the Planning Commission recommended that the Board of County Commissioners accept said Special Warranty Deed.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the Special Warranty Deed from Alfred J Linnebur Flying Service, Inc, a copy of which is attached hereto and incorporated herein by this reference, be and hereby is accepted.

SPECIAL WARRANTY DEED

THIS DEED, dated this 8th day of June 2020 between **Alfred J Linnebur Flying Service, Inc.**, whose address is 64001 US Highway 36, Byers, CO, 80103, grantor(s), and **THE COUNTY OF ADAMS, State of Colorado**, whose legal address is 4430 South Adams County Parkway, Brighton, Colorado 80601 of the County of Adams and State of Colorado, grantee(s):

WITNESS, that the grantor(s), for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, have granted, bargained, sold and conveyed, and by these presents doth grant, bargain, sell, convey and confirm, unto the grantee(s), its successors and assigns forever, all the real property, together with improvements, if any, situate, lying and being in the said County of Adams, State of Colorado, described as follows:

Legal description as set forth in Exhibit "A" attached hereto and incorporated herein by this reference.

Assessor's schedule or parcel number: part of 0181130100006 and 0181130100007

TOGETHER with all and singular the hereditaments and appurtenances thereto belonging, or in anywise appertaining, the reversion and reversions, remainder and remainders, rents, issues and profits thereof, and all the estate, right, title, interest, claim and demand whatsoever of the grantor(s), either in law or equity, of, in and to the above bargained premises, with the hereditaments and appurtenances;

TO HAVE AND TO HOLD the said premises above bargained and described, with the appurtenances, unto the grantee(s), its successors and assigns forever. The grantor(s), for itself, its successors and assigns, do covenant, grant, bargain and agree to and with the grantee(s), its successors and assigns, does covenant, and agree that it shall and will WARRANT AND FOREVER DEFEND the above bargained premises in the quiet and peaceable possession of the grantee(s), its successors and assigns, against all and every person or persons lawfully claiming the whole or any part thereof, by, through or under grantor(s), except and subject to matters of record, and except interests of record.

IN WITNESS WHEREOF, the grantor(s) have executed this deed on the date set forth above.

Alfred J Linnebur Flying Service, Inc.

By: Gary May

Print: Gary May

Title: Pres Alfred Linnebur Flying Service

STATE OF Colorado)
) §
County of Arapahoe)

The foregoing instrument was acknowledged before me this 8 day of June, 2020 Gary May, as President for Alfred Linnebur Flying

Witness my hand and official seal.
My commission expires:

CORRINA PETROSIUS
Notary Public
State of Colorado
Notary ID # 20204006748
My Commission Expires 02-18-2024

Notary Public

Name and Address of Person Creating Newly Created Legal Description (§38-35-106.5, C.R.S.)

EXHIBIT "A"

TRACT A

THE EASTERLY 60.00 FEET OF SECTION 30, TOWNSHIP 3 SOUTH, RANGE 61 WEST OF THE 6TH P.M., ADAMS COUNTY, COLORADO,

TRACT B

THE NORTHERLY 40.00 FEET OF SECTION 30, TOWNSHIP 3 SOUTH, RANGE 61 WEST OF THE 6TH P.M., ADAMS COUNTY, COLORADO, EXCEPT THE EASTERLY 60.00 FEET THEREOF

PLANNING COMMISSION FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION RECOMMENDING ACCEPTANCE OF A SPECIAL WARRANTY DEED
FROM ALFRED J. LINNEBUR FLYING J SERVICES, INC TO ADAMS COUNTY FOR RIGHT-OF-WAY PURPOSES

At a regular meeting of the Planning Commission for Adams County, Colorado, held at the County Government Center in Brighton Colorado on Thursday the 9th day of July 2020, the following proceedings, among others, were had and done, to wit:

WHEREAS, the Adams County Planning Commission has considered the advisability of accepting a Special Warranty Deed from Alfred J. Linnebur Flying J Services, Inc. for the dedication of road right-of-way for E 38th Avenue and Bradbury Krebs Road being on the following described property:

> See Legal Description as set forth in Exhibit "A" of Special Warranty Deed attached hereto and incorporated herein by this reference.

WHEREAS, this property is located in and is a Part of Section 30, Township 3 South, Range 61 West of the 6th Principal Meridian, County of Adams, State of Colorado.

NOW, THEREFORE, BE IT RESOLVED that the Adams County Planning Commission recommends to the Board of County Commissioners that said Special Warranty Deed be accepted by the Board of County Commissioners for road right-of-way as designated above.

Upon a motion duly made and seconded, the foregoing resolution was adopted.

I, Justin Martinez, Chair of the Adams County Planning Commission do hereby certify that the annexed foregoing resolution is a true and correct record of the proceedings of the Adams County Planning Commission.

Chair
Adams County Planning Commission

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Flood Insurance Assessment and Program for Public Information
FROM: Jill Jennings Golich, Director
AGENCY/DEPARTMENT: Community & Economic Development
HEARD AT STUDY SESSION ON: July 28, 2020
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the Flood Insurance Assessment and the Program for Public Information to obtain additional credit through the annual recertification of the Adams County Floodplain Management Program within the Community Rating System.

BACKGROUND:

Adams County has received Community Rating System (CRS) credit for floodplain management activities. Adams County continues to implement these activities through the Development Standards and Regulations. The Adams County Floodplain Coordinator has completed a flood insurance assessment and developed a program for public information to enhance the Adams County Floodplain Management program and to improve the score within the Community Rating System. The Community Economic and Development Department is requesting the Board of County Commissioners to approve the flood insurance assessment and authorized the program for public information.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community and Economic Development
Public Works

ATTACHED DOCUMENTS:

Resolution approving the Adams County Flood Insurance Assessment and Program for Public Information
The Adams County Flood Insurance Assessment and Program for Public Information

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE FLOOD INSURANCE ASSESSMENT
AND PROGRAM FOR PUBLIC INFORMATION FOR ADAMS COUNTY

Resolution 2020-XXX

WHEREAS, Adams County is a member of the National Flood Insurance Program and participates in the Community Rating System; and,

WHEREAS, The Community Rating System is a voluntary incentive-based program that recognizes, encourages, and rewards communities for exceeding the minimum standards of the National Flood Insurance Program; and,

WHEREAS, Adams County's floodplain management program is evaluated annually by the Insurance Services Office, Inc., a contractor for the Federal Emergency Management Agency (FEMA), to verify compliance with the National Flood Insurance Program and award points for public information activities, mapping and regulations, flood damage reduction activities, and warning and response; and,

WHEREAS, Adams County has received a Class 9 rating and has the opportunity to increase the community rating score with this year's verification cycle; and,

WHEREAS, the completion of a flood insurance assessment and the development of a program for public information are two activities that can increase Adams County's score within the Community Rating System by enhancing the current public information activities; and,

WHEREAS, the Adams County Community and Economic Development Department recommends that the Board of County Commissioners approve the Flood Insurance Assessment and Program for Public Information.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Flood Insurance Assessment and Program for Public Information For Adams County, a copy of which is attached hereto and incorporated herein by this reference, is hereby approved.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners be authorized to execute this document on behalf of the County of Adams, State of Colorado.

Flood Insurance Assessment and Program for Public Information

for Adams County

Completed by:

Theron Greg Labrie, PE, CFM
Adams County, Colorado

July 28, 2020

Approved By: _____
Chair, Board of County Commissioners

Table of Contents

Introduction

The Adams County Floodplain Management Program is scheduled to go through a verification inspection this year. One element that will enhance the Adams County Floodplain Management Program is having a flood insurance assessment with a flood insurance information improvement plan for the community. Currently, Adams County has not completed a flood insurance assessment, and the consequence of not having this analysis, is that the County has no information to determine if the flood insurance coverage for structures within the flood hazard delineation area is adequate for our community. The purpose of this analysis is twofold, to develop a flood insurance communication improvement plan and to obtain credit under the Community Rating System of the National Flood Insurance Program.

A flood insurance assessment (FIA) is an analysis of a community's level of flood insurance coverage that identifies where increased coverage would be beneficial. It is the first step toward developing a flood insurance coverage improvement plan in the community. In most cases, it is to the community's advantage to conduct the flood insurance assessment and to develop the plan as part of a local program for public information (PPI). There are five steps in the flood insurance assessment process. The first step is to collect the flood insurance information from FEMA and the state of Colorado. The next step involves calculating the level of flood insurance coverage through an extensive analysis of the data. Upon completion of the analysis, the flood insurance assessment and improvement plan shall be completed and submitted to the Adams County Leadership Team and the Board of County Commissioners. The final step involves the annual reassessment of the flood insurance improvement plan.

The Adams County Flood Insurance Assessment is a report that will provide a history of the Adams County Floodplain Management Program. It will give some insight into the National Flood Insurance Program (NFIP) and the Community Rating System. This insurance assessment will provide an analysis of the insurance policies, claims, and total paid losses for insured residential and commercial structures within unincorporated Adams County. More importantly, it will present a plan for public information on how to disseminate the message that need to be conveyed to the Adams County's constituents.

History and Background

Congress established the NFIP in 1968. The NFIP is administered by the Federal Emergency Management Agency (FEMA). The NFIP provides federally backed flood insurance to property owners in participating communities. The federal government became an insurer of flood losses through the NFIP because the private market stopped offering flood insurance. The primary reason why the private market stopped offering flood insurance is because floods violate some of the ideal conditions of insurability. More specifically, flood insurance can be subject to adverse selection, with only the riskiest properties insuring. Losses are also correlated—when a large flood occurs, many properties are all damaged simultaneously—and can be catastrophic. These aspects of flood losses can make it difficult for the private sector to insure against floods, and when private coverage is available, it can be expensive, perhaps more than households are willing or able to pay. At the time when the NFIP was created, some observers argued that the government could overcome many of these challenges, particularly by better pooling risks, setting rates to encourage broader participation, and incentivizing risk reduction measures.

The NFIP created multiple objectives to accomplish the goal of providing affordable insurance. In presentations and outreach materials, FEMA has previously compared the NFIP to a four-legged stool. Provision of flood insurance is only one of the legs. The second is promoting floodplain management, which is achieved through community regulations. The third is mapping of flood hazards on flood insurance rate maps. The final leg is hazard mitigation, promoted through grants and community incentives.

FEMA floodplain maps delineate different flood risk zones. Areas modeled as the 1 percent annual chance floodplain, or 100-year flood zone, are referred to as Special Flood Hazard Areas. FEMA also maps the floodway which is the central portion of a floodplain that carries deep and high velocity flows. The FEMA maps also include the 500-year floodplains. Since the establishment of the NFIP in 1968, communities have had a partnership role in the program. Communities can voluntarily choose to join the program. When communities agree to participate, they implement land-use management actions that can reduce claims over time; in exchange, FEMA makes flood insurance available to residents. Over the years, almost all communities at risk of flooding have joined the program. Nationwide, more than 22,000 communities now participate. The NFIP defines a community as any local jurisdiction with authority to regulate floodplain land use. When a community joins, it must adopt

minimum floodplain management regulations established by the program. The required regulations vary according to the flood zone but include the following features: (1) the community must require that all new development in SFHAs obtain a permit; (2) new development in floodways must not be permitted if it increases flood heights; and (3) all new construction, or substantially improved or damaged properties in SFHAs, must be elevated so that the lowest floor is at or above base flood elevation, which is the estimated height of floodwaters in a 100-year flood. It is also important to note that nonresidential structures can also be dry flood proofed. FEMA regional offices or NFIP State Coordinating Agencies provide model ordinances for adoption. Once communities adopt those regulations, residents are eligible to purchase flood insurance through the program. Single-family homeowners (and two- to four dwelling residences) can purchase up to $250,000 of building coverage and $100,000 of contents coverage. Nonresidential policies can insure both structure and contents up to $500,000 each. Minimum deductibles vary by policy type but are at least $1,000, with higher ones available.

The NFIP also has a voluntary program called the Community Rating System, which rewards communities that take actions to lower their flood risk. Established in 1990, the CRS awards points to communities for activities in four areas: (1) public information activities; (2) mapping and regulations; (3) flood damage reduction activities; and (4) warning and response. As a community accumulates points, it moves up through levels in the program, from class 10 to class 1. At each new class level, SFHA residents in the community receive another 5 percent discount on NFIP premiums, up to 45 percent. Outside the SFHA, residents of classes 7–9 receive a 5 percent reduction in premiums and those in classes 1–6 receive a 10 percent reduction in premiums. As of spring of 2014, 1,296 communities nationwide participated in the CRS program. Although these are only 5 percent of all communities in the NFIP, they represent more than 67 percent of all policies in force.

Adams County created their floodplain management program and joined the NFIP in 1978. The Adams County Floodplain Management Program was designed to establish reasonable limitations and controls of land uses within the 100-year floodplain. The Adams County Development Standards and Floodplain Regulations were developed to reduce flood hazards, protect the public health, safety, and general welfare, minimize flood losses, promote wise use of the floodplain, and protect the storage capacity and hydraulic character of the floodplain. The Flood Control Overlay Zone District was established with the following specific intentions: 1. Reduce flood-related hazards to life and property by restricting the use of land within flood prone areas. 2. Provide notice to floodplain

occupants of the type and location of hazards by delineating areas subject to flooding and regulating the method in which buildings and utilities are constructed. 3. Protect the public from financial burden by avoiding public expenditures on flood control and minimizing damage to property. 4. Protect the flood storage capacity of floodplains by regulating the filling and modification of the floodplain and watercourses. 5. Protect the natural hydraulic characteristics of watercourses by regulating the modification of watercourses and prohibiting encroachment into watercourses.

In 2015, the Board of County Commissioners of Adams County gave the approval to have an evaluation of the county's floodplain management program by entering the Community Rating System Program. The Adams County Floodplain Administrator was directed to complete the application for the program and submit the required documentation to FEMA showing the various floodplain prevention and mitigation activities that are performed by the County to obtain credit with the Community Rating System.

Adams County floodplain program and activities were reviewed during this verification visit and the program was upgraded to a Class 9. As a result, Adams County residents and businesses are now eligible to receive a five percent discount on flood insurance. Adams County's rating became effective on Oct. 1, 2016 and the five percent discount is now available to all flood insurance policyholders. In addition to individual savings on flood insurance, NFIP offers other benefits to the county, including educational programs for residents, increased public safety, and safeguards to minimize economic losses to private property and public infrastructure. These benefits for the citizens of Adams County can only be maintained if the County continues to complete the annual verification review of the floodplain management program. Adams County must verify that it is continuing to perform the activities that are being credited by the CRS by submitting an annual recertification. In addition, Adams County can continue to improve its Class Rating by undertaking new mitigation and floodplain management activities that earn even more points such as completing this flood insurance assessment.

Flood Insurance Assessment

The Adams County Flood Insurance Assessment was initiated by completing step 1 of the defined process. This step involved collecting insurance data from FEMA and the state of Colorado. FEMA provided information for the number of insurance policies in force by occupancy type and flood zone. The NFIP Community Assistance Program Coordinator with the state of Colorado provided general insurance policy coverage for Adams County and the surrounding area. The total number of residential and commercial structures within Adams County were obtained from the Adams County Assessor's Office. Finally, the actual number of residential and commercial structures located in a flood hazard zone were obtained from the Adams County Business Solutions Department.

The data from the charts and spreadsheets located in the appendix of this report are as follows:

• Total number of residential structures in Adams County	37,718
• Total number of commercial structures in Adams County	5,590
• Total number of residential structures in a floodplain	704
• Total number of commercial structures in a floodplain	222
• Total number of insurance policies in force for residential structures	131
• Total number of insurance policies in force for commercial structures	52
• Total claims since 1978	38
• Total payout since 1978	$114,092
• Current total premium	$246,481
• Current total coverage	$55,897,700

The above data acquired from the various organizations provided the foundation for the flood insurance assessment. The data was used to determine the level of flood insurance coverage and the amount of insurance coverage throughout Adams County. It allowed Adams County staff to calculate averages and percentages that were used to identify trends in terms of the number of policies in force, the cost of premiums, the amount of coverage, the type of structures that are covered and the general location of these structures. This insurance assessment analyzed the insurance coverage of residential, commercial, PRE-FIRM and Post-FIRM structures in and outside of the Special Flood Hazard Areas.

I. Level of Coverage

Adams County

Occupancy	Properties	Policies In Force
Residential	**37718**	**131**
Single family		123
2-4 family		1
all other residential		7
Nonresidential	**5590**	**52**
Level of residential coverage	0.3473%	
Level of nonresidential coverage	0.9302%	

The determination of flood insurance coverage level within Adams County was obtained from the most recent flood insurance policy data provided by FEMA and the state of Colorado. Information regarding the number, location and type of structures were received from the Adams County's Assessor's Department and Business Solution Department. Based on the above data, the level of insurance coverage for all residential structures within Adams County was determined to be 0.35% and the level of coverage for commercial structures was determined to be 0.93%

Adams County (SFHA)

Occupancy	Number of Units
Residential in Flood Zone (SFHA)	**704**
With coverage	79
Without Coverage	625
Nonresidential in Flood Zone (SFHA)	**222**
With coverage	52
Without Coverage	170
level of residential coverage in SFHA	11.22%
level of nonresidential coverage in SFHA	23.42%

The coverage rate for insurance is highest in the Special Flood Hazard Areas (SFHA), where flood insurance requirements are mandatory with a federally backed mortgage. Surprisingly, even though mandatory coverage is required in SFHA Zones, the residential coverage rate in Adams County is only 11.22%. One of the reasons for this low percentage rate of coverage is that many of these homes are older and more than likely no longer carry a mortgage. The level of coverage for commercial structures is over double the rate of residential structures at 23.42%. As expected, the coverage rate for insurance coverage throughout the entire county for residential and commercial structures are much lower than the coverage rate for structures within the SFHA.

II. Average Premium Coverage

Adams County

Occupancy	Polices In Force	Premium	Insurance In Force	Average Coverage
Residential				
Single family	123	$ 136,837.00	$ 31,790,900.00	$ 258,462.60
2-4 family	1	$ 421.00	$ 350,000.00	$ 350,000.00
all other residential	7	$ 23,145.00	$ 3,295,000.00	$ 470,714.29
Nonresidential	52	$ 83,611.00	$ 19,749,800.00	$ 379,803.85

The average coverage for single family homes meet the NFIP requirement of $250,000 for the structure, but if the content coverage is included, it falls short of the additional $100,000 requirement. Given the fact that the Adams County housing market continues to grow and the average home cost in Adams County is $370,000 as determined by Zillow, homeowners and the owners of the other residential units to include apartments and condos may want to evaluate if they have the appropriate amount of coverage to cover their structures. The same message can be sent to owners of commercial units with an average coverage of $379,802.85 for their structures.

Adams County

Insurance Information	
claims since 1978	38
total payout since 1978	$ 114,092.00
Current total premium	$ 246,481.00
Current total coverage	$ 55,897,700.00
Total payout since 1978 to current coverage	0.2041%
Total payout since 1978 to current premium	46.29%
Average Claim per Year	0.9268

The above chart shows that the total insurance payout since 1978 as compared to the premium that is being paid by current policy holders is at 46.3%, and the total insurance payout since 1978 as compared to current insurance coverage is at 0.20%. It is also important to note, that Adams County has averaged a little less than one claim per year for the past 42 years.

III. Pre-FIRM and Post-FIRM Comparison

	Policies in Force	Premium	Number of Claims	Amount of Paid Losses
Pre- FIRM	**81**	**$157,750**	**27**	**$84,483.66**
In Flood Zone	56	$140,976	12	$19,049.91
Outside Flood Zone	25	$16,774	15	$65,433.75
Post - FIRM	**93**	**$80,540**	**8**	**$29,477.63**
In Flood Zone	49	$ 45,686	2	$0
Outside Flood Zone	44	$34,854	6	$29,477.73

Adams County

Pre-FIRM and Post FIRM Analysis	% of Total Claims
Pre-FIRM in Flood Zone	34.3%
Pre-FIRM outside of Flood Zone	42.9%
Post-FIRM in Flood Zone	5.7%
Post-FIRM outside of Flood Zone	17.1%
	% of Total Paid Losses
Pre-FIRM in Flood Zone	16.7%
Pre-FIRM outside Flood Zone	57.4%
Post-FIRM in Flood Zone	0%
Post-FIRM outside Flood Zone	25.9%

The above charts showing insurance coverage for Pre-FIRM and Post FIRM structures inside and outside of flood zones within Adams County are the most intriguing because it shows the majority of insurance claims and the amount of paid losses are coming from owners with structures built before 1978 which are Pre-FIRM structures. The chart also illustrates that 60% of the claims which equates to 83% of paid losses occur to structures outside of the flood zones.

Conclusion

Based on the information collected, it is clear, that many of residents in Adams County do not carry flood insurance on their buildings. Residents are much more likely to purchase insurance if they are in a SFHA Zone, where purchase is mandatory with a federally backed mortgage, but even in these areas, less than a quarter of the properties are covered.

Given that the overall flood insurance coverage is generally low throughout the county, The Adams County Floodplain Management Program is recommending that our public information campaign target a variety of audiences to increase flood insurance coverage for buildings and content. The target audience will include Adams County employees, the general public, residents in the floodplain, developers, builders, real estate companies, lending companies, and insurance companies.

The Adams County Floodplain Management Program will formulate a specific message to promote insurance coverage for structures in the SFHA Zones and throughout Adams County for their target audiences. The message will include the following facts that were determined from this flood insurance assessment:

1. The likelihood of a flood varies from property to property
2. Almost no property is guaranteed to be safe from flooding
3. Properties located in flood zones are at greater risk. These properties have about a 25% chance of flooding during the term of a 30-year mortgage.
4. Properties outside of flood zones will also flood. In Adams County 60% of the claims and 83% of paid losses occur to structures outside of flood zones.
5. Homes and business structures built before 1978 are more likely to flood. In Adams County 77% of the claims and 74% of paid losses occur to Pre-FIRM structures.
6. Everyone with a mortgage on a property in a flood zone must purchase flood insurance
7. It is important to note that only flood insurance cover flood damages
8. If you do not have flood insurance, you may not qualify for post disaster federal aid to cover flood damages.
9. All home and business owners should evaluate their need for flood insurance and go to FEMA’s Floodbuddy webpage for a free quote

Program for Public Information

Well-informed people make better decisions and they take steps to protect themselves from flooding by retrofitting their homes, buying flood insurance, and planning the actions they will take during the next flood. They are also more likely to support local floodplain management efforts and measures to protect the natural functions of their community's floodplain. This program for public information (PPI) will be an ongoing local effort to identify, prepare, implement, and monitor a range of public information activities that meet specific local needs.

The Adams County program for public information will focus primarily on outreach projects. This plan will build on what is already being done. This includes current community-based public information efforts as well as initiatives by other organizations or agencies. The plan will provide for a full range of information activities that inform the general public and Adams County staff about flood insurance and ways to address potential flood damage to property, including map information, outreach projects, real estate disclosure, libraries, websites, and providing technical advice and assistance.

The standard tools that will be used to distribute this message are the flood brochures and stormwater flyers that are mailed annually to our citizens from the Mile High Flood District and from the Public Works Stormwater Management Division. A tool that will be used to enhance the program for public information will include having the flood insurance message posted on the Adams County Stormwater and Infrastructure webpage, the Emergency and Operations Management webpage and of course, the Floodplain Management webpage. The message will also be given to the Adams County Emergency Operations Center to be included in the Emergency Management Plan.

A very important method that can be used to enhance the message to the public, is to have the Adams County Board of County Commissioners to proclaim the month of April as the "Stormwater Management and Flood Awareness Month" for the entire County. During this month of every year the Community and Economic Development Department will coordinate with the Adams County Communication Department to incorporate the flood insurance message onto the Adams County intranet and social media platforms to include Twitter, Facebook, and My Adams Newsletter. Recent research has shown that the more often a message is received from different sources, the more likely it is that the desired action or behavior will take place.

In summary, Adams County staff will create a more focus message within the stormwater management division flyers and the Mile High Flood District Brochure. These two methods of communications have been very effective with disseminating the flood insurance message to the general public, metro districts, homeowner associations, and realtor groups. This program for public information also describes methods to broaden the delivery of the flood insurance message by coordinating this effort with the Communications Department, Public Works and Emergency Operations Center. This coordinated effort will involve placing the flood insurance message on the web page of each department. It will also include the placement of the flood insurance message on the Adams County official social media platforms which will expand the reach of the message to the target audience as described in the above paragraphs and it would include all of Adams County employees. Having the Board of County Commissioners to proclaim April as the “Stormwater Management and Flood Awareness Month,” is essentially one more effective tool to elevate the importance of the message. Following the scope as defined in this program for public information will effectively express the importance of flood insurance for every property owner in Adams County and allow them to make better decisions with taking steps to protect themselves from flooding by retrofitting their homes, buying flood insurance, and planning the actions they will take during the next flood.

Reassessment Procedure

The reassessment process for the flood insurance assessment and the program for public information will be initiated annually during the months of February, March, and April. The Adams County Floodplain Manager will be responsible for the reassessment process. This person will request the most current insurance data from the state of Colorado and FEMA. The information will be reviewed and analyzed by the Floodplain Manager. The results of the analysis will be compared to the previous year results to determine a specific message that will be used on the Adams County web pages and social media platforms. The floodplain manager will coordinate with Public Works, the Mile High Flood District, the Communications Department, and the Emergency Operations Center to disseminate the updated message in the brochures, newsletters, social media platforms, and web pages.

The reassessment process will also involve evaluating the public information program strategy. The Adams County Floodplain Manager, Infrastructure and Stormwater Manager, the Stormwater Coordinator, and Construction Manager will meet during this time frame to discuss the effectiveness of the current public information strategy. This evaluation will consist of comparing the changes in the level of insurance coverage from the previous year for residential and commercial structures. We will compare the changes of insurance coverage for pre-FIRM and post-FIRM structures and we will document the number of policies in force for the entire county. The results of this analysis will allow us to understand the effectiveness of the current public information strategy and provide some insight on how we can continue to improve this program.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: County Board of Equalization Appointment of Hearing Officers
FROM: Meredith P. Van Horn, Assistant Adams County Attorney; **Elizabeth A. Albright, CBOE/Abatement Coordinator**
AGENCY/DEPARTMENT: County Attorney
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoint the following candidate, Patricia K. Brandon, as a 2020 CBOE and/or Abatement and/or Property Tax Exemption Hearing Officer.

BACKGROUND:

Annually, the Board of County Commissioners, sitting as the Adams County Board of Equalization, reviews the assessment roll of all taxable real property located in the County as prepared by the Assessor. Authorization under C.R.S. § 39-8-102 allows the appointment of independent hearing officers who are experienced in property valuation to conduct hearings on appeal of these valuations, on behalf of the Board of Equalization. The Hearing Officers then make findings and submit their recommendations to the County Board of Equalization for its final action.

Hearings on real and personal property tax valuation appeals before the County Board of Equalization, must be conducted between September 16th and November 1st for 2020, and their recommendations approved on or before November 10th, pursuant to C.R.S. § 39-8-107(2).

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Assessor's Office

ATTACHED DOCUMENTS:

Resolution
Adams County Purchase of Service Agreement for Board of Equalization Hearing Officer
Resume and/or Application of Hearing Officer Applicant

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:
Cost Center:

	Object Account	**Subledger**	**Amount**
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	**Subledger**	**Amount**
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION APPOINTING HEARING OFFICER TO HEAR APPEALS BEFORE THE ADAMS COUNTY BOARD OF EQUALIZATION

WHEREAS, the Board of County Commissioners, County of Adams, State of Colorado, also comprises the Adams County Board of Equalization; and,

WHEREAS, C.R.S § 39-8-102, authorizes a County Board of Equalization to appoint independent hearing officers who are experienced in property valuation to conduct hearings on behalf of the County Board of Equalization, and to make findings and submit recommendations to the County Board of Equalization for its final action; and,

WHEREAS, Patricia K. Brandon has applied, possesses the requisite licenses and/or credentials and should be appointed to act as a hearing officer to conduct hearings pursuant to C.R.S. § 39-8-102 and C.R.S. § 39-3-206.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, when sitting as the Adams County Board of Equalization, that the person identified below, who is experienced in property valuation, is hereby appointed to act as a hearing officer to conduct hearings pursuant to C.R.S. § 39-8-102, and C.R.S. § 39-3-206, and that her compensation shall be set at the rate of $75 per hour, with a 4-hour minimum.

Name	**Address**
Patricia K. Brandon	2004 Calaveras Court Longmont, CO 80504 Phone: 720-352-3300 patty@pattbrandon.com

BE IT FURTHER RESOLVED, that the Chair is authorized to sign the Purchase of Service Agreement for the Board of Equalization Hearing Officer, for the above appointed individual.

ADAMS COUNTY, COLORADO
PURCHASE OF SERVICE AGREEMENT FOR BOARD OF EQUALIZATION HEARING OFFICER

THIS AGREEMENT ("Agreement") is made this 10th day of August 2020, by and between the Adams County Board of County Commissioners, located at 4430 S. Adams County Parkway, Brighton, Colorado 80601, hereinafter referred to as the "County," and Patricia K. Brandon, whose address is 2004 Calaveras Court, Longmont, CO 80504, hereinafter referred to as the "Contractor." The County and the Contractor may be collectively referred to herein as the "Parties."

The County and the Contractor, for the consideration herein set forth, agree as follows:

1. **SERVICES OF THE CONTRACTOR:**

Contractor shall act as a hearing officer to hear taxpayer appeals of property valuations. Contractor shall enter its findings and ruling into the County's computer system on the day of the appeal in order for the County to send timely notices to the taxpayers.

2. **RESPONSIBILITIES OF THE COUNTY:**

The County shall provide information as necessary or requested by the Contractor to enable the Contractor's performance under this Agreement. County shall provide necessary computer equipment.

3. **TERM:**

Term of Agreement: The term of this agreement shall be for year 2020 and renewable for up to 5 (five) one-year commitments, upon mutual consent of the parties.

4. **PAYMENT AND FEE SCHEDULE:**

The County shall pay the Contractor for services furnished under this Agreement, and the Contractor shall accept as full payment for those services, the sum of $75.00 (Seventy-Five Dollars) per hour with a 4 (four) hour minimum, to be paid within thirty days of the date the work is completed.

5. **INDEPENDENT CONTRACTOR:**

In providing services under this Agreement, the Contractor acts as an independent contractor and not as an employee of the County. The Contractor shall be solely and entirely responsible for his/her acts, and the acts of his/her employees, agents, servants, and subcontractors during the term and performance of this Agreement. No employee, agent, servant, or subcontractor of the Contractor shall be deemed to be an employee, agent, or servant of the County because of the performance of any services or work

under this Agreement. The Contractor, at its expense, shall procure and maintain workers' compensation insurance as required by law. **Pursuant to the Workers' Compensation Act § 8-40-202(2)(b)(IV), C.R.S., as amended, the Contractor understands that it and its employees and servants are not entitled to workers' compensation benefits from the County. The Contractor further understands that it is solely obligated for the payment of federal and state income tax on any moneys earned pursuant to this Agreement.**

6. NONDISCRIMINATION:

The Contractor shall not discriminate against any employee or qualified applicant for employment because of age, race, color, religion, marital status, disability, sex, or national origin. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices provided by the local public agency setting forth the provisions of this nondiscrimination clause.

7. INDEMNIFICATION:

The Contractor agrees to indemnify and hold harmless the County, its officers, agents, and employees for, from, and against any and all claims, suits, expenses, damages, or other liabilities, including reasonable attorney fees and court costs, arising out of damage or injury to persons, entities, or property, caused or sustained by any person(s) as a result of the Contractor's performance or failure to perform pursuant to the terms of this Agreement or as a result of any subcontractors' performance or failure to perform pursuant to the terms of this Agreement.

8. TERMINATION:

8.1. For Cause: If, through any cause, the Contractor fails to fulfill its obligations under this Agreement in a timely and proper manner, or if the Contractor violates any of the covenants, conditions, or stipulations of this Agreement, the County shall thereupon have the right to immediately terminate this Agreement, upon giving written notice to the Contractor of such termination and specifying the effective date thereof.

8.2. For Convenience: The County may terminate this Agreement at any time by giving written notice as specified herein to the other party. If this Agreement is terminated by the County, the Contractor will be paid an amount that bears the same ratio to the total compensation as the services actually performed bear to the total services the Contractor was to perform under this Agreement, less payments previously made to the Contractor under this Agreement.

9. MUTUAL UNDERSTANDINGS:

9.1. Jurisdiction and Venue: The laws of the State of Colorado shall govern as to the

interpretation, validity, and effect of this Agreement. The parties agree that jurisdiction and venue for any disputes arising under this Agreement shall be Adams County, Colorado.

9.2. Compliance with Laws: During the performance of this Agreement, the Contractor agrees to strictly adhere to all applicable federal, state, and local laws, rules and regulations, including all licensing and permit requirements. The parties hereto aver that they are familiar with § 18-8-301, et seq., C.R.S. (Bribery and Corrupt Influences), as amended, and § 18-8-401, et seq., C.R.S. (Abuse of Public Office), as amended, and that no violation of such provisions are present. Without limiting the generality of the foregoing, the Contractor expressly agrees to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when exposed to or provided with any data or records under this Agreement that are considered to be "Protected Health Information."

9.3. OSHA: Contractor shall comply with the requirements of the Occupational Safety and Health Act (OSHA) and shall review and comply with the County's safety regulations while on any County property. Failure to comply with any applicable federal, state or local law, rule, or regulation shall give the County the right to terminate this agreement for cause.

9.4. Record Retention: The Contractor shall maintain records and documentation of the services provided under this Agreement, including fiscal records, and shall retain the records for a period of three (3) years from the date this Agreement is terminated. Said records and documents shall be subject at all reasonable times to inspection, review, or audit by authorized federal, state, or County personnel.

9.5. Assignability: Neither this Agreement, nor any rights hereunder, in whole or in part, shall be assignable or otherwise transferable by the Contractor without the prior written consent of the County.

9.6. Waiver: Waiver of strict performance or the breach of any provision of this Agreement shall not be deemed a waiver, nor shall it prejudice the waiving party's right to require strict performance of the same provision, or any other provision in the future, unless such waiver has rendered future performance commercially impossible.

9.7. Force Majeure: Neither party shall be liable for any delay or failure to perform its obligations hereunder to the extent that such delay or failure is caused by a force or event beyond the control of such party including, without limitation, war, embargoes, strikes, governmental restrictions, riots, fires, floods, earthquakes, or other acts of God.

9.8. Notice: Any notices given under this Agreement are deemed to have been

received and to be effective: (1) three (3) days after the same shall have been mailed by certified mail, return receipt requested; (2) immediately upon hand delivery; or (3) immediately upon receipt of confirmation that a facsimile was received. For the purposes of this Agreement, any and all notices shall be addressed to the contacts listed below:

Adams County Attorney's Office 4430 S. Adams County Parkway 5th Floor, Suite C5000B Brighton, Colorado 80601 Phone: 720-523-6116 Fax: 720-523-6114
Adams County Board of Equalization Contact: Elizabeth A. Albright Address: 4430 S. Adams County Parkway, 5th Floor, Suite C5000B Brighton, Colorado 80601 Phone: 720-523-6328 Fax: 720-523-6114 Email: balbright@adcogov.org
Patricia K. Brandon 2004 Calaveras Court Longmont, CO 80504 Phone: 720-352-3300 Email: patty@pattybrandon.com

9.9. Integration of Understanding: This Agreement contains the entire understanding of the parties hereto and neither it, nor the rights and obligations hereunder, may be changed, modified, or waived except by an instrument in writing that is signed by the parties hereto.

9.10. Severability: If any provision of this Agreement is determined to be unenforceable or invalid for any reason, the remainder of this Agreement shall remain in effect, unless otherwise terminated in accordance with the terms contained herein.

9.11. Authorization: Each party represents and warrants that it has the power and ability to enter into this Agreement, to grant the rights granted herein, and to perform the duties and obligations herein described.

10. COMPLIANCE WITH C.R.S. § 8-17.5-101, ET. SEQ. AS AMENDED 5/13/08: Pursuant to Colorado Revised Statute (C.R.S.), § 8-17.5-101, *et. seq.*, as amended 5/13/08, the Contractor shall meet the following requirements prior to signing this Agreement (public contract for service) and for the duration thereof:

10.1. The Contractor shall certify participation in the E-Verify Program (the electronic employment verification program that is authorized in 8 U.S.C. § 1324a and jointly administered by the United States Department of Homeland Security and the Social Security Administration, or its successor program) or the Department Program (the employment verification program established by the Colorado Department of Labor and Employment pursuant to C.R.S. § 8-17.5-102(5)) on the attached certification.

10.2. The Contractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

10.3. The Contractor shall not enter into a contract with a subcontractor that fails to certify to the Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

10.4. At the time of signing this public contract for services, the Contractor has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this public contract for services through participation in either the E-Verify Program or the Department Program.

10.5. The Contractor shall not use either the E-Verify Program or the Department Program procedures to undertake pre-employment screening of job applicants while this public contract for services is being performed.

10.6. If Contractor obtains actual knowledge that a subcontractor performing work under this public contract for services knowingly employs or contracts with an illegal alien, the Contractor shall: notify the subcontractor and the County within three days that the Contractor has actual knowledge that the subcontractor is employing or contracting with an illegal alien; and terminate the subcontract with the subcontractor if within three days of receiving the notice required pursuant to the previous paragraph, the subcontractor does not stop employing or contracting with the illegal alien; except that the contractor shall not terminate the contract with the subcontractor if during such three days the subcontractor provides information to establish that the subcontractor has not knowingly employed or contracted with an illegal alien.

10.7. Contractor shall comply with any reasonable requests by the Department of Labor and Employment (the Department) made in the course of an investigation that the Department is undertaking pursuant to the authority established in C.R.S. § 8-17.5-102(5).

10.8. If Contractor violates this Section, of this Agreement, the County may terminate this Agreement for breach of contract. If the Agreement is so terminated, the Contractor shall be liable for actual and consequential damages to the County.

IN WITNESS WHEREOF, the Parties have caused their names to be affixed hereto.

Adams County Board of Equalization NA Emma Pinter	 Date:
Approved as to Form NA Meredith P. VanHorn Assistant County Attorney Adams County Attorney's Office	 Date:
Signature: Name: Patricia Brandon	8/6/2020 Date:

COUNTY OF ADAMS)
)ss
STATE OF COLORADO)

Signed and sworn to before me this 6th day of August, 2020 by Patricia K. Brandon.

PAM LAUER
Notary Public
State of Colorado
Notary ID # 19994035917
My Commission Expires 01-05-2024

Pam Lauer
Notary Public

My commission expires on: 1-5-2024

LAWFUL PRESENCE AFFIDAVIT

I, Patricia Brandon, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

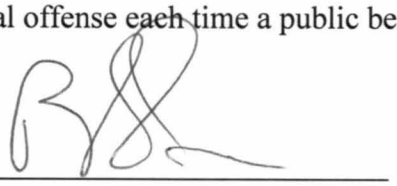
✓ I am a United States Citizen, or

_____ I am a legal Permanent Resident of the United States, or

_____ I am otherwise lawfully present in the United States pursuant to Federal law

(note: additional verification will be required through the "SAVE" program*).

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.



Signature

8/4/20

Date

COUNTY USE ONLY

Identification Produced (check one):

✓ Colorado Drivers License

____ Colorado Identification Card

____ United States Military Card

____ United States Military Dependent's Card

____ United States Coast Guard Merchant Mariner Card

____ Native American Tribal Document

____ *Verification to be completed through the "SAVE" program.

Identification produced to Elizabeth J Albright, of Adams County. EAA

Name of county employee Initials

PATRICIA K BRANDON

Real Estate Broker Associate - REALTOR®

2004 Calaveras Court, Longmont, CO 80504 | 720-352-3300 | patty@pattybrandon.com

Licensed and professional residential REALTOR® providing top notch experience and high level skills regarding client support and communication, guidance in strategy and negotiation, data collection, research, and analysis, problem solving, contract accuracy and compliance, print and Internet marketing, as well as coordination and multitask management.

PROFESSIONAL EXPERIENCE

REALTOR® / BROKER ASSOCIATE | *RE/MAX of Boulder, Inc.* | *2012 to Present* | ***CO License #100039762***

- Provide exceptional customer service to guide clients through the home buying and selling process while ensuring a high level of accuracy and confidentiality
- Develop marketing materials to generate leads, maintain clients, gain referrals
- Experience with a variety of residential property types: single family, condos, townhomes, farm and ranch, mixed use communities, and new construction
- Real estate programs: CTMe, DocuSign, IRES, LoneWolf, Matrix, Showingtime, SkySlope, SureClose

ADMINISTRATIVE ASSISTANT | *RE/MAX of Boulder, Inc.* | *2003 to 2007 & 2010 to 2012*

- Listing management and transaction coordination, including data entry, file auditing, calendar and contract organization
- Documentation auditing to ensure Federal, State, and Local compliance (ie. annual forms purge and organization, EPA LBP audit, attorney review follow up)
- Stepped into leadership role in the absence of the Office Manager
- Earned a solid reputation throughout the office as a professional willing to always go that extra mile
- Assisted in hiring and training of staff

EMPLOYEE HEALTH SERVICES INTERN | *All Children's Hospital* | *2009*

- Developed "ACH (Always Choose Health)," the health and wellness portion of the All Children's employee intranet
- Coordinated all aspects of the "Cold Turkey" cafeteria event to highlight the Great American Smokeout®
- Co-taught Fit4AllKids, a 9-week class series on constructing healthy lifestyle changes

EMPLOYEE WELLNESS INTERN | *Poudre Valley Health System* | *2009*

- Performed extensive research on weight and stress management programs and composed informative articles on Heart Health for weekly and monthly internal newsletters
- Designed engaging educational resources focusing on the benefits of proper time management practices, stress management, heart health, smoking cessation, and others.
- Composed informative articles on Heart Health for weekly and monthly internal newsletters

WELLNESS COORDINATOR | *Hospitality Valuation Services (HVS)* | *2008-2009*

- Successful at defining individualized wellness programs for 52 employees which entailed providing one-on-one support to assist each employee in achieving their wellness goals
- Created monthly wellness flyers, "Healthy Hearts" cookbook. Presented "Wellness" at annual meeting.

CO-DIRECTOR | *Victoria's Secret* | *2000 to 2002*

- Delivered key leadership, organizational support, and HR functions throughout entire location with a core focus on providing an outstanding client experience
- Co-managed 10-15 total employees depending upon season, 2-4 at any given time

EDUCATION / MEMBERSHIPS

REAL ESTATE LICENSE: Broker Associate | State of Colorado | 2012 to Present | License #100039762

MEMBER: BARA | CAR | NAR | IRES | REColorado

BACHELOR OF SCIENCE: Health & Exercise Science, Health Promotion | Colorado State University | 2010

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Resolution Regarding Defense and Indemnification of Bradley Guildner as a Defendant Pursuant to C.R.S. § 24-10-101, *et seq.*, 19-CV-3255-RM-MEH
FROM: Heidi Miller, County Attorney, County Attorney and Kerri Booth, Assistant County Attorney
AGENCY/DEPARTMENT: County Attorney's Office
HEARD AT STUDY SESSION ON N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Adopt the Resolution Regarding Defense and Indemnification of Bradley Guildner as a Defendant Pursuant to C.R.S. § 24-10-101, *et seq*.

BACKGROUND:

The Board of County Commissioners formally indemnifies employees and elected officials who are named in civil lawsuits. This lawsuit is brought by Siera Ryans who claims she was the victim of unreasonable search and seizure, excessive force, and assault and battery by the Defendants when she was attempting to enter the Adams County Courthouse.

The County Attorney's Office has reviewed the facts of this lawsuit and it has been determined that Bradley Guildner was acting within the course and scope of his employment at all relevant times relevant to this lawsuit. Therefore, the County Attorney's Office is recommending that Bradley Guildner be indemnified for any potential damages that might arise out of this litigation.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Sheriff's Office

ATTACHED DOCUMENTS:

RESOLUTION REGARDING DEFENSE AND INDEMNIFICATION OF BRADLEY GUILDNER AS A DEFENDANT PURSUANT TO C.R.S. § 24-10-101, ET SEQ.

FISCAL IMPACT:

Please check if there is no fiscal impact☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

Potential fiscal impact is unknown. If litigation results in settlement or judgment against the County or its employees/elected officials, there would be a fiscal impact. The potential amount of that impact is impossible to estimate at this time.

RESOLUTION REGARDING DEFENSE AND INDEMNIFICATION OF BRADLEY GUILDNER AS A DEFENDANT PURSUANT TO C.R.S. § 24-10-101, ET SEQ.

WHEREAS, Adams County is a public entity pursuant to the Colorado Governmental Immunity Act; and,

WHEREAS, Adams County is obligated to bear the cost of the defense of its elected officials and employees and pay all judgments entered against its elected officials and employees pursuant to the Colorado Governmental Immunity Act so long as they acted within the course and scope of their employment and their acts were not willful and wanton; and,

WHEREAS, in Resolution 2020-153, the Board of County Commissioners of Adams County agreed to indemnify the other Defendants previously named in this matter; and,

WHEREAS, Bradley Guildner has been sued in the matter of *Siera Ryans v. Bradley Guildner, et al.* in the United States District Court, Case Number 19-cv-03255-MEH; said Defendant, being an employee of Adams County at the time of the incident described in the Second Amended Complaint; and,

WHEREAS, initial investigation has revealed to the satisfaction of the Board of County Commissioners and the determination has been made that the Defendant appears to have acted within the course and scope of his employment and his actions do not appear to be willful and wanton; and,

WHEREAS, pursuant to C.R.S. §§ 24-10-110, 24-10-113 and 24-10-118(5) Adams County hereby determines that it is in the public interest to bear the cost of defense for the Defendant against all asserted claims for compensatory and punitive damages which may be pled and to pay or settle any such compensatory and punitive damage claims against said Defendant; and,

WHEREAS, in exchange for such defense, the Defendant is required to cooperate fully in the defense of this matter, including but not limited to, assisting in the discovery process, participating in mediation, facilitation, or other measures deemed appropriate by the Board of County Commissioners, and Defendant acknowledges that Adams County may settle on behalf of the Defendant any or all asserted claims, including those for personal liability and punitive damages.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners of the County of Adams, State of Colorado, that Adams County shall bear the cost of defense for Bradley Guildner against all asserted claims for compensatory and punitive damages which may be pled and to pay or settle any such compensatory and punitive damage claims against said Defendant in the matter of *Siera Ryans v. Bradley Guildner, et al.*

IT IS FURTHER RESOLVED that the Adams County Attorney is directed to enter her appearance as counsel for Defendant and to defend this matter.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Abatements
FROM: Meredith P. Van Horn, Assistant Adams County Attorney
AGENCY/DEPARTMENT: County Attorney
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the recommendations of the Assessor's Office for the attached abatement petitions.

BACKGROUND:

The Assessor's Office reviewed the attached abatement petitions concerning tax year 2019 and has agreed to the abated values for the respective accounts. The findings and recommendations of the Assessor's Office are attached hereto for approval and adoption.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Assessor's Office

ATTACHED DOCUMENTS:

Resolution
Summary Findings and Recommendations of the Assessor's Office

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION APPROVING ABATEMENT PETITIONS AND AUTHORIZING THE REFUND OF TAXES FOR ACCOUNT NUMBERS R0139133, P0034733, R0007009, R0162582, R0055160, R0188047, R0100719, R0077815, R0118564, R0064210, R0121751, R0147811, and R0175821

WHEREAS, pursuant to C.R.S. § 39-1-113, the Board of County Commissioners may approve abatement petitions concerning property tax assessment and may refund taxes associated therewith; and,

WHEREAS, the attached petitions for account numbers R0139133, P0034733, R0007009, R0162582, R0055160, R0188047, R0100719, R0077815, R0118564, and R0064210 have been processed, reviewed and approved by the Adams County Assessor's Office; and,

WHEREAS, information regarding the initial assessed value and the justification for reduction in assessed value and refund of taxes is included for each property in the documentation attached; and,

WHEREAS, it is the recommendation of the Assessor's Office that these petitions be approved and refunds be issued by the Board of County Commissioners; and,

WHEREAS, for account numbers R0121751, R0147811, and R0175821, approval by the Board of County Commissioners shall be forwarded as a recommendation to the Colorado Property Tax Administrator for review and approval as required by C.R.S. §§ 39-1-113(3) and 39-2-116.

NOW, THERFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the abatement petitions for account numbers R0139133, P0034733, R0007009, R0162582, R0055160, R0188047, R0100719, R0077815, R0118564, and R0064210 are hereby approved.

BE IT FURTHER RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the resolution approving the petitions for account numbers R0121751, R0147811, and R0175821 be forwarded, for review, to the Colorado Property Tax Administrator to approve the abatement petitions for the Property.

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

ASSESSOR LEVEL

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): Parcel N0.(S) 01569-03-3-12-001

2. The subject property is classified as a Residential property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$91,000
Improvements	$381,018
Total	$472,018

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$91,000
Improvements	$294,000
Total	$385,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: July 8, 2020

Petitioner's Representative

Whitney Nickelson

Digitally signed by Whitney Nickelson
DN: cn=Whitney Nickelson, o, ou, email=wnickelson@adcogov.org, c=US
Date: 2020.07.08 15:26:12 -06'00'

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0139133 Parcel No : 01569-03-3-12-011
Petition Year : 2019 AND 2020 Date Filed : June 17, 2020
Owner Entity : HANNAH AND KANE SEELEY
Owner Address : 4280 PIONEER PLACE
Owner City : BRIGHTON State : CO
Property Location : 4280 PIONEER PLACE, BRIGHTON

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL		L:		L: **$91,000**	**$6,510**	A. Ratio	7.15%
		I:		I: **$381,018**	**$27,240**	Mill Levy	173.206
TOTALS :		**$385,000**	**$27,530**	**$472,018**	**$33,750**	Original Tax	**$5,846**

Tax Exempt Portion
0%

Petitioner's Statement :

Home is not worth appraised value. No basement.

Assessor's Report

Situation :

Action :

Recommendation :

Upon further review, a reduction in value appears warranted. Home was purchased for 385,000 on 3/29/2019.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL		L: **$91,000**	**$6,510**	L: **$91,000**	**$6,510**		**$1,077.34**
		I: **$381,018**	**$27,240**	I: **$294,000**	**$21,020**	Revised Tax	
TOTALS :		**$472,018**	**$33,750**	**$385,000**	**$27,530**		**$4,768.36**

Whitney Nickelson July 9, 2020
Appraiser Date

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received _____
(Use Assessor's or Commissioners' Date Stamp)

Section I: Petitioner, please complete Section I only.

Date: 06 (Month) 14 (Day) 2020 (Year)

Petitioner's Name: Kane ? Hannah Seeley

Petitioner's Mailing Address: 4280 Pioneer Pl.

Brighton (City or Town) CO (State) 80601 (Zip Code)

SCHEDULE OR PARCEL NUMBER(S)

0156903312001

R0139133

PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY

Residence - 4280 Pioneer Pl.
Brighton, CO 80601

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for property tax year(s) 2019 and 2020 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error or overvaluation. Attach additional sheets if necessary.)

Petitioner's estimate of value: $385,000 (Value) (2019) (Year) and $405,000 (Value) (2020) (Year)

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information and belief, is true, correct, and complete.

Petitioner's Signature

Daytime Phone Number (636) 352 5282

Email hcseeley@gmail.com

By _____
Agent's Signature*

Daytime Phone Number (____) _____

Email _____

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

	Tax Year _____			Tax Year _____		
	Actual	Assessed	Tax	Actual	Assessed	Tax
Original						
Corrected						
Abate/Refund						

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

_____
Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/15

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: **Written Mutual Agreement of Assessor and Petitioner**
(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

	Tax Year _____			Tax Year _____		
	Actual	Assessed	Tax	Actual	Assessed	Tax
Original						
Corrected						
Abate/Refund						

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature Date

_____ _____
Assessor's or Deputy Assessor's Signature Date

Section IV: **Decision of the County Commissioners**
(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ (***being present--not present***), and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED, that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor and the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund	Year	Assessed Value	Taxes Abate/Refund

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: **Action of the Property Tax Administrator**
(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this abatement petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

ABATEMENT FOR TAX YEAR: 2017

BUSINESS NAME:	Hook Fish Branding			
ACCOUNT NUMBER:	P0034733			
PARCEL NUMBER:				
	ACTUAL VALUE	ASSESSED VALUE	MILL LEVY	TAX DOLLARS
ORIGINAL VALUE	$96,846	$28,090	108.565	$3,049.59
REVISED VALUE	$61,448	$17,820	108.565	$1,934.63
ABATED VALUE	$35,398	$10,270	108.565	$1,114.96

Provide your reason for the Abatement/Added in the space below:

Being double assessed

ADDED ASSESSMENT FOR TAX YEAR:

BUSINESS NAME:				
ACCOUNT NUMBER:				
PARCEL NUMBER:				
	ACTUAL VALUE	ASSESSED VALUE	MILL LEVY	TAX DOLLARS
ORIGINAL VALUE		$0		$0.00
REVISED VALUE		$0	0	$0.00
ADDED VALUE	$0	$0	0	$0.00

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received 07/17/2020
(Use Assessor's or Commissioners' Date Stamp)

Section I: Petitioner, please complete Section I only.

Date: 07/17/2020
Month Day Year

Petitioner's Name: Adams County Assessor

Petitioner's Mailing Address: 4430 S. Adams County Pkwy

Brighton CO 80601
City or Town State Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
	2531 W 62ND CT #F
	P0034733

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2017 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

Petitioner's estimate of value: $ 61448 (Value) (2017) (Year)

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Linda A. Frank
Petitioner's Signature

Daytime Phone Number (720) 523-6736

Email LFrank@adcogov.org

By _____
Agent's Signature*

Daytime Phone Number (_____)

Email _____

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

_____
Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/15

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature **Date**

_____ _____
Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on _____/_____/_____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

Ken Musso
Assessor

RECEIVED

MAY 19 2020

OFFICE OF THE
ADAMS COUNTY ASSESSOR

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

ASSESSOR LEVEL

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): Parcel N0.(S) 01569-28-0-00-001

2. The subject property is classified as a Residential property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$109,000
Improvements	$532,127
Total	$641,127

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$109,000
Improvements	$364,045
Total	$473,045

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: May 5, 2020

Albert J. Rodriguez
Petitioner's Representative

Whitney Nickelson
Digitally signed by Whitney Nickelson
DN: cn=Whitney Nickelson, o, ou, email=wnickelson@adcogov.org, c=US
Date: 2020.05.05 14:18:51 -06'00'

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0007009 Parcel No : 01569-28-0-00-001
Petition Year : 2019 Date Filed : March 26, 2020
Owner Entity : RODRIGUEZ, ALBERT
Owner Address : 18100 E 136TH AVE
Owner City : BRIGHTON State : CO
Property Location : SAME

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL		L:		L: **$109,000**	**$7,790**	A. Ratio	7.15%
		I:		I: **$532,127**	**$38,050**	Mill Levy	93.482
TOTALS :		**$500,000**	**$35,750**	**$641,127**	**$45,840**	Original Tax	**$4,285**

Tax Exempt Portion
0%

Petitioner's Statement :

Two Story dwelling is no longer habitable.

Assessor's Report

Situation :

Action :

Improvement should be at zero value.

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL		L: **$109,000**	**$7,790**	L: **$109,000**	**$7,790**		**$1,123.65**
		I: **$532,127**	**$38,050**	I: **$364,045**	**$26,030**	Revised Tax	
TOTALS :		**$641,127**	**$45,840**	**$473,045**	**$33,820**		**$3,161.56**

Whitney Nickelson July 29, 2020
Appraiser Date

RECEIVED
MAR 06 2020
OFFICE OF THE
ADAMS COUNTY ASSESSOR

PETITION FOR ABATEMENT OR REFUND OF TAXES

County Adams

Date Received MAR 06 2020

Section I: Petitioner, please complete Section I only.

Date 3 6 2020
Month Day Year

Petitioner's Name Albert J Rodriguez

Petitioner's Mailing Address 18100 East 136th Ave

Brighton Co 80603
City or Town State Zip Code

#117470

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
R0007009	

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year _____ are incorrect for the following reasons. (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

Second dwelling no longer liveable

Petitioner's estimate of value: $ 500 ac R 2019
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Albert J Rodriguez
Petitioner's Signature

Daytime Phone Number 303.659-5141

Email barrlaker@outlook.com

By: _____
Agent's Signature*

Daytime Phone Number ( )

Email _____

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-1 (4), C.R.S., denies the petition for an out-of-state/county taxpayer, whether in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision. § 39-10-114(1)(a)(I)(B), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ Assessor recommends approval as outlined above.

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection on protest to such valuation has been filed and a Notice of Determination has been mailed, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ Assessor recommends denial for the following reason(s):

_____
Assessor's or Deputy Assessor's Signature

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY

(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition. § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year: _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____

Petitioner's Signature — Date

_____ _____

Assessor's or Deputy Assessor's Signature — Date

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____ at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition and are fully advised in relation thereto.

NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund

_____

Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____
Month Year

_____

County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners relative to this petition is hereby:

☐ Approved ☐ Approved in part $ _____ ☐ Denied for the following reason(s):

_____ _____ _____

Secretary's Signature — Property Tax Administrator Signature — Date

Ken Musso

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

Board of County Commissioners
STIPULATION (As to Tax Year(s) 2019 Actual Value)

1. The property subject to this Stipulation is PARCEL NO. (S): 0156523201008 Schedule No. (S): R0162582

2. The subject property is classified as Vacant Land property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) 2019:

Land	$ 129,600
Improvements	$0
Total	$ 129,600

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) 2019:

Land	$ 90,000
Improvements	$ 0
Total	$ 90,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s)2019.

DATED this: August 4, 2020

Petitioner's Representative

Skye Phillips
Assessor's Representative

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0162582 Parcel No : 0156523201008
Petition Year : 2019 Date Filed : July 16, 2020
Owner Entity : Walter J and Peggy E Griffin
Owner Address : PO Box 726
Owner City : Lyons State : CO
Property Location : 14100 Indianfield Court, Hudson, CO 80642

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL		L: $95,000		L: **$129,600**	**$37,580**	A. Ratio	29.00%
		I:		I:	**$0**	Mill Levy	114.623
TOTALS :		**$0**	**$0**	**$129,600**	**$37,580**	Original Tax	**$4,308**

Tax Exempt Portion
0%

Petitioner's Statement :

We believe the taxes levied are an overvaluation of the property.

Assessor's Report

Situation :

The larger lot in Eastern Adams County was calculated by the model incorrectly.

Action :

The assessed value was reviewed and adjusted.

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL		L: **$129,600**	**$37,580**	L: **$90,000**	**$26,100**		**$1,315.87**
		I: **$0**	**$0**	I:	**$0**	Revised Tax	
TOTALS :		**$129,600**	**$37,580**	**$90,000**	**$26,100**		**$2,991.66**

Skye Phillips August 4, 2020
Appraiser Date

Certified Residential Appraiser

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received _____
(Use Assessor's or Commissioners' Date Stamp)

JUL 16 2020
OFFICE OF THE
ADAMS COUNTY ASSESSOR

Section I: **Petitioner, please complete Section I only.**

Date: 07 / 12 / 2020
Month Day Year

Petitioner's Name: WALTER V. & Peggy E. GRIFFIN

Petitioner's Mailing Address: P.O. Box 726

Lyons. CO 80540
City or Town State Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
0156523201008	14100 Indianfield Ct.

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

We believe the taxes levied are an overvaluation of the property.

Petitioner's estimate of value: $95,000 (2019)
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Walter V. Griffin
Petitioner's Signature

Daytime Phone Number (303) 823-5335

Email stonemtnmomma@AOL.com

Peggy E. Griffin
By _____
Agent's Signature*

Daytime Phone Number (_____) _____

Email _____

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

_____
Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/15

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature Date

_____ _____
Assessor's or Deputy Assessor's Signature Date

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ (***being present--not present***), and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

ABATEMENT

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0055160 Parcel N0.(S) 0171925206003

2. The subject property is classified as a Residential property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$78,000
Improvements	$384,063
Total	$462,063

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$78,000
Improvements	$186,272
Total	$264,272

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: August 3, 2020

Petitioner's Representative
Carlos Arreola

Pierre Lescano
Digitally signed by Pierre Lescano
DN: cn=Pierre Lescano, o=Adams County, ou=Adams County Assessor's Office, email=plescano@adcogov.org, c=US
Date: 2020.08.03 14:45:08 -06'00'

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0055160 Parcel No : 01719-25-2-06-003
Petition Year : 2019 Date Filed : March 26, 2020
Owner Entity : Carlos Arreola
Owner Address : 8571 Hope Ct
Owner City : Denver State : CO
Property Location : 8570 McDougal St

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	100	L:		L: **$78,000**	**$5,580**	A. Ratio	7.15%
		I:		I: **$384,063**	**$27,460**	Mill Levy	100.745
TOTALS :		**$300,000**	**$21,450**	**$462,063**	**$33,040**	Original Tax	**$3,329**

Petitioner's Statement :

The property is new construction and is not finished.

Assessor's Report

Situation :

Applicant informed us that the property was not finished. I scheduled a field check to go see it. The property was not finished and the applicant submitted inspection reports that corroborated his statement.

Action :

I ran comps taking into account that the property was unfinshed and that supported a reduction.

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL	100	L: **$78,000**	**$5,580**	L: **$78,000**	**$5,580**		**$1,424.53**
		I: **$384,063**	**$27,460**	I: **$186,272**	**$13,320**	Revised Tax	
TOTALS :		**$462,063**	**$33,040**	**$264,272**	**$18,900**		**$1,904.08**

Pierre Lescano
Digitally signed by Pierre Lescano
DN: cn=Pierre Lescano, o=Adams County, ou=Adams County Assessor's Office, email=plescano@adcogov.org, c=US
Date: 2020.08.04 09:52:25 -06'00'

August 4, 2020

Appraiser Date

Ad Valorem Appraiser

RECEIVED

PETITION FOR ABATEMENT OR REFUND OF TAXES

County Adams

Date Received (Date Assessor's or Commissioners' Date Stamp) MAR 12 2020

OFFICE OF THE
ADAMS COUNTY ASSESSOR

PL

Section I: Petitioner, please complete Section I only.

Date: 03 (Month) 03 (Day) 2020 (Year)

117472

Petitioner's Name Carlos Arreola

Petitioner's Mailing Address 8571 Hope ct

Denver (City or Town) CO (State) 80229 (Zip Code)

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
0171929206003	8570 McDougal St Denver, CO 80229
R0055160	

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons. (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

Petitioner's estimate of value: $ 320,000 (Value) 2019 (Year)

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Petitioner's Signature

Daytime Phone Number (720) 940-9852

Email

By Agent's Signature*

Daytime Phone Number ( )

Email

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision. § 39-10-114.5(1), C.R.S.

Section II: Assessor's Recommendation
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ Assessor recommends approval as outlined above.

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer. § 39-10-114.5(2)(a), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ Assessor recommends denial for the following reason(s):

Assessor's or Deputy Assessor's Signature

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition. § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature **Date**

_____ _____
Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto,
NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 not scheduled, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby:
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

Home Search New Schedule Submittal Instructions

Announcements Logged in as Carlos Arreola Collections (0) Account Management Logout

Search...

Record BDP17-3585:
Building Permit - Plan Review Required
Record Status: Permit Issued

Add to collection

Record Info Payments Custom Component

Work Location

8570 McDOUGAL

Record Details

Applicant:
Reina Fernandez
8571 Hope Ct
Denver, CO 80229
Primary Phone: 720-982-9923
Secondary Phone: 720-982-9923
[illegible]

Owner:
ARREOLA CARLOS
8571 HOPE CT
DENVER CO 802295151

Project Description:
Single Family Dwelling
Single Family Dwelling

RECEIVED
MAR 12 2020
OFFICE OF THE
ADAMS COUNTY ASSESSOR

More Details

I am requesting an abatement for my property because it is a new construction and it is not completely finished. The property is about 70% complete and we are working on getting the final two inspections. The papers attached show the inspections that were completed in 2018 and throughout 2019. You can contact us for additional information to Carlos or Reina (720)982-9923


Home
Search
New
Schedule
Submittal Instructions
Record BDP17-3585:
Building Permit - Plan Review Required
Record Status: Permit Issued
Add to collection
Record Info
Payments
Custom Component
Inspections
Upcoming
Schedule or Request an Inspection
Completed (13)
View Details
View Details
View Details
1
2
3
Next >

Home Search New Schedule Submittal Instructions

Announcements Logged in as Carrie Simons Collections (0) Account Management Logout

Search

Record BDP17-3585: Add to collection
Building Permit – Plan Review Required
Record Status: Permit Issued

Record Info ▾ Payments ▾ Custom Component

Inspections

Upcoming

Schedule or Request an Inspection

You have not added any inspections.
Click the link above to schedule or request one.

Completed (13)

Failed 160 All Roughs/Gas (133981) View Details
Result by: Chris Bertrand on 09/28/2018 at 01:26 PM

Passed 160 All Roughs/Gas (133366) View Details
Result by: Chris Bertrand on 09/10/2018 at 01:10 PM

Passed 205 Insulation (135317) View Details
Result by: Raul Trejo on 09/28/2018 at 12:07 PM

Passed 210 Drywall (144397) View Details
Result by: Donnie Tomlinson on 03/27/2019 at 02:30 PM

Cancelled 245 Final Electrical Inspection (156652) View Details
Cancelled by: Erin McMannes on 08/21/2019 at 11:52 AM

« Prev 1 2 3 Next »

Floor & Decor
7350 W 52nd Ave
Arvada, CO 80002
(303) 420-1030

Date 07/03/2019 Time 12:52 PM

Transaction Number 10117045866729[illegible]
Store 117 Register 4
Associate [illegible] Abbie

SALE

Retail
[illegible]
70655990 [illegible] 1
GLA WINTER CIDER LEAF 85.80
10024630 [illegible] 1
WOOD FLOORING SAMPLE 119.92
9491000001 T @ 5.00 1
5.00

Retail Subtotal 210.72
Sales Tax 16.77
Retail Total 227.49
Orders
Storage Bay Order SBO117[illegible]

Amount 3,770.44

Orders Total 3,770.44

Grand Total

[illegible]

Invoice Number: [illegible]

Entry: Chip
[illegible] Issuer
AID: A0000000[illegible]
TVR: 8080008000
IAD: 0601040360[illegible]
TSI: e800
ARC: 00

Customer Carlos Ar[illegible]
Customer ID 800071[illegible]
Receipt from Quoted Tra[illegible]
7e1170001522

Low Prices, [illegible]

*X10117045866729[illegible]

Floor & Decor Return Policy
F&D reserves the right to limit or deny returns. Used or opened [illegible] to be defective, can be returned [illegible] 90 days of purchase. Please see [illegible]

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

COUNTY BOARD OF EQUALIZATION

STIPULATION (As to Tax Year(s) 2019-2020 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0188047 Parcel N0.(S) 1573-12-2-04-031

2. The subject property is classified as a Residential property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019-2020**:

Land	$100,000
Improvements	$434,738
Total	$534,738

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019-2020**:

Land	$100,000
Improvements	$296,100
Total	$396,100

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019-2020**.

DATED this: August 6, 2020

Andy Biaggi Digitally signed by Andy Biaggi Date: 2020.08.07 09:31:52 -06'00'

Petitioner's Representative
Andrew and Krista Biaggi
15072 Fillmore Way
Thornton Co 80602

Jeff Maldonado Digitally signed by Jeff Maldonado DN: cn=Jeff Maldonado, o, ou, email=jemaldonado@adcogov.org, c=US Date: 2020.08.06 15:20:47 -06'00'

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0188047 Parcel No : 1573-12-2-04-031
Petition Year : 2019 Date Filed : June 5, 2020
Owner Entity : Andrew and Krista Biaggi
Owner Address : 15072 Fillmore Way
Owner City : Thornton State : Co
Property Location : CUNDALL FARMS SUBD NO 1 AMND NO 3 BLK 13 LOT 14-A

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL		L: $100,000		L: **$100,000**	**$7,150**	A. Ratio	7.15%
		I: $296,100		I: **$434,738**	**$31,080**	Mill Levy	179.982
TOTALS :		**$0**	**$0**	**$534,738**	**$38,230**	Original Tax	**$6,881**

Tax Exempt Portion
0%

Petitioner's Statement :

Significant increase in value. Questions whether it's a clerical or overvaluation error

Assessor's Report

Situation :

Subject sale during base period - New construction

Action :

Value adjusted to May 2018 new build purchase price

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL		L: **$100,000**	**$7,150**	L: **$100,000**	**$7,150**		**$1,783.62**
		I: **$434,738**	**$31,080**	I: **$296,100**	**$21,170**	Revised Tax	
TOTALS :		**$534,738**	**$38,230**	**$396,100**	**$28,320**		**$5,097.09**

Jeff Maldonado August 10, 2020
Appraiser Date

Ad Valorem Appraiser

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received _____
(Use Assessor's or Commissioners' Date Stamp)

Section I: **Petitioner, please complete Section I only.**

Date: June 5, 2020
Month Day Year

Petitioner's Name: Andrew Biaggi

Petitioner's Mailing Address: 15072 Fillmore Way, Thornton, CO 80602

City or Town State Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
0157312204031	15947 Clayton St. Thornton CO 80602

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

The total property value is significantly higher than 2019 value of $396,100. The assessor has the total property value at $534,738.00. This appears to be a clerical or overvaluation error.

Petitioner's estimate of value: $ 396,100.00 (2018)
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

A. Biaggi
Petitioner's Signature

Daytime Phone Number (720) 326-5922

Email biaggi255@yahoo.com

By _____
Agent's Signature*

Daytime Phone Number (_____) _____

Email _____

***Letter of agency must be attached when petition is submitted by an agent.**

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ **Protest?** ☐ **No** ☐ **Yes (If a protest was filed, please attach a copy of the NOD.)**

☐ **Assessor recommends denial for the following reason(s):**

_____
Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/15

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature **Date**

_____ _____
Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on _____/_____/_____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ (***being present--not present***), and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

_____	_____	_____
Year	Assessed Value	Taxes Abate/Refund

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____	_____	_____
Secretary's Signature	Property Tax Administrator's Signature	Date

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

BOARD OF COUNTY COMMISSIONERS

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0064210 Parcel N0.(S) 0171931205028

2. The subject property is classified as a Commercial property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) 2019:

Land	$259,875
Improvements	$251,850
Total	$511,725

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) 2019:

Land	$259,875
Improvements	$185,125
Total	$445,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) 2019.

DATED this: August 3, 2020

Petitioner's Representative
Dan George
1st Net Real Estate Services, Inc
3333 South Wadsworth Blvd., D 1
Lakewood, CO 80227

Deb Myer Digitally signed by Deb Myer DN: cn=Deb Myer, o=Adams County, ou=Assessor's Office, email=dmyer@adcogov.org, c=US Date: 2020.08.02 08:24:09 -06'00'

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0064210 Parcel No : 0171931205028
Petition Year : 2019 Date Filed : March 3, 2020
Owner Entity : Westminster, LLC
Owner Address : PO Box 926
Owner City : Westcliffe State : CO 81252
Property Location : 4850 W 80th Ave., Westminster, CO

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	344	L: $259,875	**$75,360**	L: **$259,875**	**$75,360**	A. Ratio	29.00%
		I: **$160,125**	**$46,440**	I: **$251,850**	**$73,040**	Mill Levy	102.653
TOTALS :		**$420,000**	**$121,800**	**$511,725**	**$148,400**	Original Tax	**$15,233.71**

Petitioner's Statement :

Enclosed petition for abatement for the tax year of 2019.

Assessor's Report

Situation :

Reviewed the taxpayer agent's submitted documents. Property consists of two 1977 office building, 1,485 SF each.

Recommendation : ***$420,000*** 2,970 SF $141.41

Upon further review, recommend valuation reduction based on a revised income approach to value.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL	1344	L: **$259,875**	**$75,360**	L: **$259,875**	**$75,360**		**$1,986.34**
		I: **$251,850**	**$73,040**	I: **$185,125**	**$53,690**	Revised Tax	
TOTALS :		**$511,725**	**$148,400**	**$445,000**	**$129,050**		**$13,247.37**

Deborah L. Myer August 11, 2020
Appraiser Date

#117444

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: ADAMS

Date Received: _____
(Use Assessor's or Commissioners' Date Stamp)

RECEIVED
MAR 09 2020
OFFICE OF THE
ADAMS COUNTY ASSESSOR

Section I: Petitioner, please complete Section I only.

Date: March (Month) 3 (Day) 2020 (Year)

Petitioner's Name: WESTMINSTER LLC

Petitioner's Mailing Address: C/O 1st Net Real Estate Services Inc

LAKEWOOD (City or Town) COLORADO (State) 80227 (Zip)

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
R0064210	4850 W. 80TH AVE.

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.) The actual income of the subject and market sales in the area of the subject support the requested value. (See Attached)

Petitioner's estimate of value: $ 420,000 (Value) (2019 (Year))

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

_____ Daytime Phone Number: (See Authorization
Petitioner's Signature
Email: _____

By: Dan George Daytime Phone Number: (720) 962-5750
Agent's Signature*

Printed Name: Dan George Email: dgeorge@1stnetre.com

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-110, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision. § 39-10-114.5(1), C.R.S.

Section II: Assessor's Recommendation
(For Assessor's Use Only)

Tax Year: _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer. § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

_____
Assessor's or Deputy Assessor's Signature

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY

(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____

Petitioner's Signature Date

_____ _____

Assessor's or Deputy Assessor's Signature Date

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____ at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)*** and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto; NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____

Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____

County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby:

☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____

Secretary's Signature Property Tax Administrator's Signature Date

1st Net Real Estate Services, Inc., 3333 S. Wadsworth Blvd. Ste 200
Lakewood, CO 80227, Phone: 720-962-5750 - Fax: 720-962-5760

LETTER OF AUTHORITY

To Whom It May Concern:

I, Glenn Seibel, am the owner, and/or agent of the owner, of the following real and/or business personal property:

ADDRESS	PARCEL/SCHEDULE NUMBER	COUNTY
4850 W. 80th Ave.	Schedule # R0064210	Adams County

I do hereby authorize 1st Net Real Estate Services, Inc. to represent my interests and to appear on my behalf before County Assessor, County Board of Equalization, Board of County Commissioners, the Colorado Board of Assessment Appeals, binding arbitration, District Court, all Colorado state courts, and/or any other agency or entity with regard to all matter(s) concerning the valuation and taxation of the above mentioned property(s) for the tax years of 2019 and 2020.

The undersigned requests that copies of all decisions from any of the above entities, or any other agency or entity, as is involved pertaining to matters of valuation and/or taxation for the above-mentioned property(s), be mailed to:

1st Net Real Estate Services, Inc.
3333 S. Wadsworth Blvd. Suite 200
Lakewood, CO 80227
Phone: (720) 962-5750
Fax: (720) 962-5760

I hereby expressly revoke any and all previous authorizations relating to the Property(s). This authorization shall remain in effect until this authorization is terminated in a written instrument executed by the undersigned.

Dated this THIRD day of MARCH 2020

Owner: WESTMINSTER, LLC

Signature: Glenn Seibel

Print Name: Glenn Seibel

Title: Managing Member

Address: PO Box 926

City, State, Zip: Westcliffe CO 80252

Phone: 719-783-2627 Fax #:

STATE OF COLORADO)
) SS
COUNTY OF Custer)

Sworn to and subscribed before me this 3rd day of March 2020 by Glenn Seibel

Witness my hand and official seal

My Commission expires 2-14-2021

Peggy E Miller

Notary Public

Address 205 S. 6th St.
Westcliffe, CO 81252

PEGGY E MILLER
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20174006865
MY COMMISSION EXPIRES FEBRUARY 14, 2021

4850-60 W. 80th Ave.

Total Operating Revenue				2018
2,000 Rentable SF	@	$ 12.80		$ 25,600
1,000 Rentable SF	@	$ 9.00		$ 9,000
		Vacancy	5%	$ (1,280.00)
				$ 33,320

Operating Expense		2018	
Management	3%	1,000	
Reserve	5%	1,666	
Total Expenses		$ 2,666	$ 2,666
Expenses Per SF		$ 1.33	

Net Income from Rental Real Estate		$ 30,654
Capitalization Rate	7.00%	7.0%
Indicated Property Value		$ 437,920

2019 County Value $ 511,725

LEASE

This Commercial Building Lease is entered into this _1st__ day of February, 2007, between Glenn Seibel and Doreen Seibel, whose address is P.O. Box 926, Westcliffe, CO 81252 ("Landlord") and Martha E Skelton, ,Skelton Family LLC, whose address is 4880 W. 80th Westminster, CO 80030 ("Tenant").

1 PREMISES AND TERM.

1.1 *Lease of Premises.* Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, the premises located at 4850 W 80th and 4880 W 80th Westminster, CO 80030, together with all improvements including all sidewalks and parking areas, together with all personal property and fixtures thereon owned by Landlord (hereinafter collectively "the Leased Premises").

1.2 *Term.* This lease shall commence on the day of closing (the "Commencement Date") and shall terminate five (5) years after the Commencement Date, unless sooner terminated or extended as herein provided. Landlord and Tenant agree that this is a triple net lease and that Tenant shall be responsible for all obligations which are normally imposed on the owner of real estate with respect to the responsibility for the payment of all real estate taxes, special assessments, insurances premiums, repair, replacement and maintenance costs in connection therewith and that these operating expenses shall be paid to the Landlord by the Tenant under the "additional rent" provisions listed below.

1.3 *Options to Renew.* Tenant shall have two options to extend this lease for five-year terms, at market rate. If Tenant wishes to exercise this option to extend, he shall deliver to Landlord written notice of his desire to extend at least 90 days prior to the end of the existing Lease term.

1.4 *Condition of Premises.* The Leased Premises are leased in an "as is" condition without any warranties or statements, express or implied, as to physical or structural condition or merchantability or as to the suitability of the Leased Premises for Tenant's intended use as professional office. Landlord shall not be responsible nor have any liability whatsoever at any time for loss or damage to Tenant's work or to fixtures, equipment, or other property of Tenant installed or placed by Tenant in the Leased Premises.

1.5 *Contingency.* This Lease is specifically contingent upon Landlord purchasing and having a successful closing on the Leased Premises from the current owner.

2 RENT.

2.1 *Monthly Rent.* The term "rent" shall mean the amounts set forth in this subparagraph. The first installment of rent for the first month of this Lease shall be due and payable on the Commencement Date of this Lease by Tenant. Thereafter, each monthly installment of rent plus estimated Operating Expenses shall be due and payable on or before the first day of each calendar month during the term of this Lease. Tenant covenants and agrees to pay to Landlord as "Base Rent" for the Premises the base rent plus the "additional rent" as outlined below. Beginning on the third year of this agreement the rent will increase each year on the anniversary of the Rent Commencement Date as outlined below.

2.2 Base rent for the first two years will be computed at the rate of $12.00 per square foot (3,000 sf) which equals $3,000. per month

Beginning on the third year and through the fourth year the base rent will be increased 40 cents per square foot to $12.40 per square foot (3,000 sf) which equals $3,100. per month.

Beginning on the fifth year the base rent will be increased 40 cents per square foot to $12.80 per square foot (3,000 sf) which equals $3,200. per month.

2.3 Tenant also agrees to pay as "additional rent" for operating expenses which is computed at the rate of $3.23 per square foot (3,000) which equals $808.50 per month. This "additional rent" shall be adjusted annually for any increase in real estate taxes, insurance or building maintenance expenses. Within ninety (90) days following the close of each calendar year, Landlord shall provide Tenant an accounting showing in reasonable detail all computations of Operating Expenses due under this paragraph. Tenant shall pay any Operating Expenses due under this paragraph within thirty (30) days following receipt of the invoice or accounting showing additional Operating Expenses.

2.4 *No Set Off.* Tenant waives and disclaims any present or future right to withhold any rent payment or other payment due under this Lease, or to set off in any action for rent, as a result of any obligation of Landlord, however incurred, and agrees that it will not claim or assert any right to so withhold or set off.

2.5 *Late Charge.* Any rental or other sums payable hereunder by Tenant which are not paid within ten (10) days after due shall bear interest from the date due to the date paid at the rate of eighteen percent (18%) per annum or the highest rate permitted by law, whichever is less. In addition to the above, Tenant shall pay Landlord a Seventy-five Dollar ($75.00) service charge for all monthly rent payments not paid by the tenth (10th) day of the month for which they are payable.

2.6 *Utilities*. Tenant shall place in Skelton Family LLC name and pay when due all charges and expenses for electricity, gas, water, wastewater, telephone, trash services and all other utilities servicing the Leased Premises directly to the provider of such utilities and services. If Tenant fails to pay any utility or service bill by the date the bill is due, Landlord shall have the right to pay the full amount due to the utility company or service provider and this amount shall be an obligation of Tenant to Landlord, payable on demand, and shall accrue interest as set forth in subparagraph 2.3.

2.7 *Security Deposit*. Tenant shall pay Landlord a security deposit in the amount of $3,000.00 upon the Commencement Date. The security deposit shall be held by Landlord for the performance of Tenants covenants and obligations under this Lease, it being expressly understood that the security deposit shall not be considered an advance payment of rental or a measure of Landlord's damage in case of default by Tenant. Upon the occurrence of any event of default by Tenant or breach by Tenant of Tenant's covenants under this Lease, Landlord may from time to time and without prejudice to any other remedy, use the security deposit to the extent necessary to make good any arrears of rent, or to repair any damage or injury, or pay any expense or liability incurred by Landlord as a result of the event of default or breach of covenant, and any remaining balance of the security deposit shall be returned by Landlord to Tenant within thirty (30) days after termination of this Lease. If any portion of the security deposit is so used or applied, Tenant shall upon ten (10) days written notice deposit with Landlord an amount sufficient to restore the security deposit to her original amount.

3 PERMITTED USES. The Leased Premises at 4850 W 80th shall be for an existing dental practice. For 4860 W 80th it is agreed that Tenant reserves the right to sub-lease a portion of the improvements to another Tenant who is acceptable to Tenant and whose primary business is acceptable to the Landlord. This sub-letting does not absolve the Tenant of any responsibilities under this lease and no portion of this lease may be assigned to sub-letting Tenant. Tenant shall, at her sole cost and expense, comply with all laws, ordinances, codes, and regulations regarding the use and condition of the Leased Premises and the operation of the permitted uses upon the Leased Premises.

4 CONSTRUCTION/IMPROVEMENTS.

4.1 *Tenant Improvements*. Tenant shall not make or allow to be made any alterations or physical additions in or to the Leased Premises without first obtaining the written consent of Landlord; (all such additional alterations and improvements are hereinafter referred to as the "Tenant Improvements"). Tenant Improvements shall be done in a workmanlike manner in accordance with industry standards and shall comply with all laws, ordinances, codes and regulations governing the Leased Premises and the construction of Tenant Improvements. Tenant shall pay contractors and laborers for Tenant Improvements and not allow any

mechanic's lien to arise which is not removed or bonded over within thirty (30) days of filing. Tenant shall indemnify, defend and hold Landlord harmless from and against any liability, loss, damage, and cost or expenses, including attorney's fees, on account of any claims or any nature, including claims of liens of labor or material or others for work performed for or materials or supplies furnished to Tenant or persons claiming under Tenant. All Tenant Improvements to the Leased Premises shall remain upon the Leased Premises and become the property of Landlord upon expiration or termination of the Lease, unless such Tenant Improvements can be removed by Tenant without damage to the Leased Premises. Specifically, Tenant may remove the following items: All dental x-ray units and cabinetry purchased as equipment and not leasehold improvements and all trade fixtures.

4.2 *Signage.* Tenant may use the signage currently in place either attached to the building, not attached to the building or affixed as vinyl letters and graphics to the glass windows and doors. There shall be no other signage.

4.3 *Removal of Tenant Improvements.* All electronic, phone and data cabling and related equipment (collectively, "Cabling") shall be and remain the property of Tenant. Upon the expiration or earlier termination of this Lease, Tenant shall, at her sole expense, remove all such Cabling and repair any damage to the Leased Premises or the building caused by such removal. If Tenant fails to remove any such items or repair such damage promptly after the expiration or earlier termination of this Lease, Tenant shall be deemed to have abandoned the same, in which case Landlord may store the same at Tenant's expense, or appropriate the same for itself, and/or sell the same in its discretion, with no liability to Tenant. The foregoing provisions shall survive the expiration or earlier termination of this Lease.

5 MAINTENANCE AND REPAIRS.

5.1 *Tenant's Obligations.* Tenant shall, at her own expense, properly maintain the interior of the Leased Premises in clean, sanitary, and safe condition and keep the Leased Premises in good order, condition, and repair. This obligation shall include all interior walls and partitions, plumbing systems and fixtures, electrical systems and fixtures. If necessary or required by governmental authority, Tenant shall make alterations, improvements, or replacements to the Leased Premises to comply with all laws, ordinances, codes, and regulations regarding the Leased Premises and the operation of the permitted and required uses upon the Leased Premises. Tenant shall not permit any waste, damage, or injury to the Leased Premises. Tenant shall keep the walkways and parking areas free from snow and ice and other debris and shall at all times keep the Leased Premises in a sanitary and clean condition.

5.2 *Repairs by Landlord.* Landlord shall be obligated for repairs, maintenance, or improvements to the exterior of Leased Premises. These repairs, maintenance or

improvements will be accounted for under the "additional rent" provision and will be paid to the Landlord by the Tenant. Any capital expense will be amortized over its useful life

6 INDEMNITY. Tenant shall indemnify, defend and hold Landlord harmless from and against any and all claims, actions, liability, costs, expenses, and damages of every kind and nature, including reasonable attorney's fees arising from (1) Tenant's use and occupancy of the Leased Premises, (2) any breach or default by Tenant under the provisions of the Lease, or (3) from any act, omission, or negligence on or about the Leased Premises by Tenant, her agents, contractors, employees, sub lessees, licensees, customers, or other third party. In case of any action or proceeding brought against Landlord by reason of any such claim, Tenant, at Landlords option, shall defend such action or proceeding by counsel reasonably satisfactory to Landlord

7 INSURANCE

7.1 *Property Insurance.* Landlord shall obtain a policy or policies of insurance with the premiums paid in advance, issued by and binding upon some solvent insurance company, insuring the Leased Premises against all risk or direct physical loss. Tenant shall maintain, at her own cost and expense, fire and extended coverage insurance in an amount adequate to cover the cost of replacement of all personal property, Tenant Improvements, alterations, changes, decorations, additions, fixtures, inventory and improvements in the Leased Premises in the event of a loss, with companies and in form acceptable to Landlord. The insurance which Tenant agrees to carry in this paragraph shall insure the full insurable value of the improvements installed by Tenant or Landlord in the Leased Premises.

8 DESTRUCTION.

8.1 *Rebuild.* If the Leased Premises are partially or totally destroyed by fire or other casualty insured under standard fire and extended coverage insurance so as to become partially or totally untenantable, the same shall be repaired as speedily as possible at Landlord's expense to the extent insurance proceeds are available (unless Landlord shall elect not to rebuild, as hereinafter provided), and the rent shall be abated until so repaired based upon the time and to the extent the Leased Premises are untenantable.

8.2 *Termination of Lease.* If the Leased Premises are destroyed or damaged by fire or other casualty then Landlord may, if it so elects, rebuild or restore the Leased Premises pursuant to paragraph 1 of this Paragraph, or may, at its election by notice in writing within thirty (30) days after such destruction or damage, terminate this Lease. In no event in the case of any such destruction shall Landlord be required to repair or replace Tenant's stock in trade, inventory,

Tenant Improvements, fixtures, furniture, furnishings or floor coverings and equipment.

9 EMINENT DOMAIN.

9.1 *Complete Taking.* If the entire Leased Premises are taken by power of eminent domain, then the term of this Lease shall end on the date possession is taken.

9.2 *Partial Taking.* In the event of a partial taking of the Leased Premises by power of eminent domain, the Lease shall continue in full force and effect unless Tenant's business operations are substantially and permanently impaired and he can no longer practically continue to operate her business, in which event the term of the Lease shall end on the date of the partial taking.

10 ASSIGNMENT AND SUBLETTING.

10.1 *Assignment Prohibited.* Tenant shall be allowed to sublet the Leased Premises. No sub-letting shall release Tenant of any of her obligations under this Lease or be construed or taken as a waiver of any of Landlord's rights hereunder. The acceptance of rent from someone other than Tenant shall not be deemed to be a waiver of any of the provisions of this Lease or a consent to any assignment or subletting of the Leased Premises.

10.2 *Trustee or Receivership.* Neither this Lease nor any interest therein shall pass to any trustee or receiver in bankruptcy, or any assignee for the benefit of creditors, or by operation of law.

11 ASSESS TO LEASED PREMISES. Landlord and Landlord's authorized representatives shall have the right to enter upon the Leased Premises during all business hours for the purpose of inspecting the same or of making repairs, additions, or alterations which Tenant has failed to perform or which Landlord deems advisable. Per HIPPA requirements, Tenant requires reasonable notice for any inpections.

12 ENVIRONMENTAL.

12.1 *Hazardous Material Defined.* The term hazardous material means any substance (1) the presence of which requires investigation or remediation under any federal, state, or local statute, regulation, ordinance, order, action, policy, or common law; or (2) which is or becomes defined as a hazardous waste, hazardous substance, pollutant, or contaminant under any feceral, state, or local statute, regulation, rule, or ordinance or amendments thereto including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act (42 U S C section 9601, et seq.) and/or the Resource Conservation and Recovery Act (42 U.S C. section 6901, et seq.); or (3) the presence of which on the Leased Premises causes or threatens to cause a nuisance upon the Leased Premises or

to adjacent properties or poses or threatens to pose a hazard to the health or safety of persons on or about the Leased Premises; or (4) without limitation, which contains gasoline, diesel fuel, or other petroleum hydrocarbons.

12.2 *Prohibiting Hazardous Materials.* Except in strict compliance with all environmental laws, rules, and regulations for materials commonly used in Tenants day-to-day business operations, Tenant shall not cause, permit, or allow any hazardous materials to be brought upon, treated, generated, or used upon the Leased Premises by Tenant, her agents, employees, contractors, invitees, or other third parties. Tenant shall promptly take all actions required by federal, state, or local government to remediate the Leased Premises in the event of the presence or release of any hazardous materials as a result of the actions or omissions of Tenant, her agent, employees, contractors, invitees, or other third parties. Tenant shall immediately notify Landlord of the presence or release of any hazardous materials requiring such remedial action.

12.3 *Indemnity.* Tenant agrees to indemnify, defend, reimburse and hold harmless Landlord for all claims, damages, judgments, losses, penalties, fines, liabilities, costs, and expenses, including attorney's fees, incurred as a result of the presence of hazardous materials upon the Leased Premises occurring after possession by Tenant or the violation of any federal, state, or local environmental law, ordinance, or regulation by Tenant, her agent, employees, contractors, invitees, or other third parties.

13 OFAC REPRESENTATIONS. Tenant represents and warrants to Landlord that Tenant is currently in compliance with and shall at all times during the term of this Lease (including any further extensions or renewals) remain in compliance with the regulations of the Office of Foreign Assets Control ("OFAC") of the United States Department of the Treasury (including those named on OFAC's Specially Designated and Blocked Persons List) and any statute, executive order (including the September 24, 2001, Executive Order Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit or Support Terrorism), or other governmental action relating thereto.

14 REMEDIES.

14.1 *Time is of the Essence.* Time is of the essence in all matters concerning this Lease. Any delay on the part of Landlord in exercising any right or insisting upon the performance of any obligation of Tenant shall not constitute a waiver of Landlords right to exercise these rights or insist upon these performances in the future.

14.2 *Events of Default.* The following events shall be deemed to be events of default by Tenant under this Lease:

14.2.1 Failure to pay any installment of rent or any other charge provided herein, or any portion thereof, when the same shall be due and payable after ten day written notice;

14.2.2 Failure to comply with any other provision of this Lease upon failure to cure such failure within fifteen (15) days after Landlord, by written notice, has informed Tenant of such non-compliance. In the case of a default which cannot with due diligence be cured within a period of fifteen (15) days, Tenant shall have such additional time to cure same as may be reasonably necessary, provided Tenant proceeds promptly and with due diligence to cure such default after receipt of said notice;

14.2.3 If any of the following occurs with respect to Tenant under this Lease:

14.2.3.1 A voluntary petition for relief pursuant to the bankruptcy or insolvency laws of the United States or of any state is filed by Tenant,

14.2.3.2 An involuntary petition for relief pursuant to the bankruptcy or insolvency laws of the United States or of any state is filed against Tenant;

14.2.3.3 The attachment, seizure, levy upon, or taking of possession by any receiver, custodian, or assignee for the benefit of creditors of any portion of the property of Tenant;

14.2.3.4 Tenant makes an assignment for the benefit of creditors;

14.2.3.5 Tenant conducts and activity or permits anyone to conduct any activity that is unlawful under any federal, state or local law.

14.2.4 Tenant ceases to conduct her normal business operations in the Leased Premises or vacates or abandons the same and leaves the same vacated or abandoned for a period of thirty (30) days; or

14.2.5 Tenant permits or permits to be done anything which creates a lien upon the Leased Premises which is not paid or discharged within thirty (30) days of the filing thereof.

14.3 *Notice of Default.* In the event of a default pursuant to subparagraph 2, Landlord may, by serving three (3) days written notice upon Tenant, elect either to:

14.3.1 Cancel and terminate this Lease, or

14.3.2 Terminate Tenant's right to possession only without terminating this Lease.

If Landlord gives Tenant notice of Tenant's default and/or delivers to Tenant a Notice of Demand for Payment or Possession pursuant to the applicable statute

(either of which shall hereinafter be referred to as a "Notice of Default"), the Notice of Default will not constitute an election to terminate the Lease unless Landlord expressly states in the Notice of Default that it is exercising its right to terminate the Lease.

14.4 *Termination of Right to Possession Only.* If Landlord delivers to Tenant a Notice of Default, which notice does not state that Landlord has elected to terminate the Lease, Landlord may at Landlord's option enter the Leased Premises and take and hold possession thereof, without such entry into possession terminating this Lease or releasing Tenant in whole or in part from Tenant's obligation to pay the rent hereunder for the full stated term. Upon such re-entry, Landlord may remove all persons and property from the Leased Premises and such property may be stored in a public warehouse or elsewhere at the cost of, and for the account of Tenant, until it is deemed abandoned or until it is claimed by Tenant, in which case Tenant agrees to pay Landlord on demand all expenses incurred in such removal, including court costs, attorneys fees and storage charges for any length of time the personal property shall be in storage, all without service of notice and without being deemed guilty of trespass or becoming liable for any loss or damage which may be occasioned thereby. Upon and after entry into possession without termination of the Lease, Landlord may, but need not, relet the Leased Premises, or any part thereof, for the account of Tenant, to any person, firm, or corporation, other than Tenant, for such rent, for such time, and upon such terms as Landlord, in Landlord's sole discretion, shall determine. Landlord shall not be required to accept any tenant offered by Tenant or to observe any instruction given by Tenant about such reletting. In any such case, Landlord may make repairs, redecorate, and remodel the Leased Premises to the extent deemed by Landlord necessary or desirable, and Tenant shall, upon demand, pay the cost thereof, together with Landlord's expenses of reletting. If the consideration collected by Landlord upon any such reletting for Tenant's account, after deducting all expenses incident thereto, including brokerage fees and legal expenses, is not sufficient to pay monthly the full amount of the rent provided in this Lease, Tenant shall pay Landlord the amount of each monthly deficiency upon demand. At any time after Landlord has elected to terminate Tenant's right to possession, Landlord shall have the right to cancel and terminate this Lease by serving five (5) days written notice on Tenant of such further election. Landlord shall have the right to pursue any remedy at law or in equity that may be available to Landlord. Such termination shall not excuse Tenant of future rents due under the Lease for the remaining term.

14.5 *Termination of Lease.* If Landlord delivers to Tenant a Notice of Default which states that Landlord has elected to terminate the Lease, Landlord shall be entitled to recover from Tenant liquidated damages in an amount equal to the amount of rent which would be payable under the terms of the Lease for the remainder of the Lease term if the Lease had not been terminated. Landlord and Tenant acknowledge that the damages incurred by Landlord in the event of Tenant's default would be difficult to ascertain because of the difficulty of

quantifying the adverse effect of such termination on the leaseability, mortgageability, saleability, and general economic value of the Leased Premises and that the amount of rent which would be payable under the Lease for the remainder of the Lease term is a fair estimate of Landlords damages and thus does not constitute a penalty.

14.6 *Future Rent*. The fact that Tenant may not continue to conduct her business operations upon the Leased Premises shall not excuse the future rent due hereunder for the remaining term of the Lease.

14.7 *Tenant's Property*. If Tenant fails to remove any of Tenant's personal property within three (3) days of receipt of a Notice of Default or upon the termination of this Lease for any cause whatsoever or upon Tenant's abandonment of the Leased Premises, Landlord, at Landlord's option, may remove the same in any manner that it shall choose and store the same without liability to Tenant for loss thereof in any public or private warehouse until it is claimed by Tenant or deemed abandoned, in which case Tenant agrees to pay Landlord on demand any and all expenses incurred in such removal, including court costs and attorney's fees and storage charges for any length of time the personal property shall be in storage; or Landlord, at Landlord's option, without notice, may sell such personal property, or any of it, pursuant to the Lease terms or Colorado law.

14.8 *Landlord's Right to Cure*. In the event of any default hereunder by Tenant, Landlord may immediately or at any time thereafter, without notice, cure such default for the account and at the expense of Tenant. If Landlord at any time by reason of such default is compelled to pay or elects to pay any sum of money or do any act which will require the payment of any sum of money, or is compelled to incur any expense, including reasonable attorneys fees, the sum or sums so paid by Landlord, with interest thereon at the rate of eighteen percent (18%) per annum or the highest rate permitted by law, whichever is less, from the date of payment thereof shall be deemed to be due from Tenant to Landlord within ten (10) days of written notice.

14.9 *Right of Entry*. In the event of Tenants default hereunder, Landlord may, in addition to all other rights and remedies, upon proper court order, re-enter the Leased Premises, change any and all of the locks on doors or other barriers, and distain, seize, remove, or store all property upon the Leased Premises. Tenant hereby agrees that such acts by Landlord pursuant to court order shall not constitute an eviction, constructive or otherwise, shall not terminate the Lease, and shall not render Landlord liable for trespass, forcible entry and detainer conversion, or in any other way whatsoever. Tenant shall pay all costs and expenses incurred by Landlord in doing such acts.

14.10 *Attorney's Fees and Costs*. In the event of Tenant's default hereunder, Tenant shall pay Landlord all costs and expenses, including reasonable attorney's fees,

incurred by Landlord in recovering from Tenant any amounts due hereunder or in otherwise enforcing this Lease.

15 SURRENDER OF POSSESSION

15.1 *Surrender of Possession.* Upon the expiration or termination of the Lease, whether by lapse of time or otherwise, Tenant shall surrender the Leased Premises in good condition and repair, reasonable wear and tear excepted. If the Leased Premises are not surrendered at the end of the term or the sooner termination thereof, Tenant shall indemnify Landlord against loss or liability resulting from delay by Tenant in so surrendering the Leased Premises. Tenant shall promptly surrender all keys for the Leased Premises to Landlord at the place then fixed for payment of rent.

15.2 *Holdover Tenant.* In the event Tenant remains in possession of the Leased Premises after the expiration of the tenancy created hereunder with the consent of Landlord and without execution of a new lease, it shall be deemed to be Occupying the Leased Premises as a tenant from month to month, at the amount of rent payable by Tenant immediately prior to the expiration of the tenancy, subject to all other conditions, provisions, and obligations of this Lease insofar as the same are applicable to a month-to-month tenancy.

15.3 *Subordination.* Tenant agrees that this Lease shall be subordinate to any mortgages, trust deeds, or ground leases that may currently exist or may hereafter by placed upon the Leased Premises and to any and all advances to be made there under, and to the interest thereon, and all renewals, replacements, and extensions thereof, provided that the mortgagee or trustee there under shall agree to recognize Tenant's rights hereunder as long as Tenant is not in default hereunder, and Tenant shall adorn to such mortgagee or trustee. Tenant shall execute and deliver whatever instrument may be required for the above purposes, and failing to do so within ten (10) days after demand in writing, does hereby make, constitute, and irrevocably appoint Landlord as its attorney-in-fact in its name, place, and stead so to do. Tenant shall in the event of the sale or assignment of Landlord's interest in the Leased Premises, or in the event of any proceedings brought for the foreclosure of, or in the event of exercise of the power of sale under any mortgage made by Landlord covering the Leased Premises, attorn to the purchaser and recognize such purchaser as Landlord under this Lease.

16 GENERAL PROVISIONS

16.1 *No Other Relationship.* Nothing contained herein shall be deemed or construed by anyone as creating the relationship of principal and agent, partnership, or joint venture between the parties hereto.

16.2 *Cumulative Remedies.* The various rights and remedies contained herein shall not be considered as exclusive of any other right or remedy, but shall be cumulative and in addition to every other remedy now or hereafter existing at law, in equity, or by statute.

16.3 *Nonwaiver.* No delay or omission of the right to exercise any power by either party shall impair any such right or power, or shall be construed as a waiver of any default or as acquiescence therein. One or more waivers of any covenant, term, or condition of this Lease by either party shall not be construed by the other party as a waiver of a subsequent breach of the same covenant, term, or condition. The consent or approval by either party to or of any act by the other party of a nature requiring consent or approval shall not be deemed to waive or render unnecessary consent to approval of any subsequent similar act.

16.4 *Binding Effect.* The covenants, agreements, and obligations contained herein shall extend to, bind, and inure to the benefit not only of the parties hereto but their respective personal representatives, heirs, successors, and assigns, subject to Article 10.

16.5 *Acceptance of Rent.* No payment by Tenant or receipt by Landlord of a lesser amount than the amount then due under this Lease shall be deemed to be other than on account of the earliest portion thereof due nor shall any endorsement or statement on any check or any letter accompanying any check or payment be deemed an accord and satisfaction, and Landlord may accept such check or payment without prejudice to Landlord's right to recover the balance due or pursue any other remedy provided in this Lease.

16.6 *Severability.* Unenforceability of any provision contained in this Lease shall not affect or impair the validity of any other provision of this Lease.

16.7 *Governing Law.* The laws of the State of Colorado shall govern the validity, performance, and enforcement of this Lease.

16.8 *Zoning.* Anything to the contrary elsewhere contained, this Lease and all of the terms, covenants, and conditions hereof are in all respects subject and subordinate to al. zoning restrictions affecting the Leased Premises, and Tenant agrees to be bound by such restrictions. Landlord does not warrant that any license or licenses, permit or permits, which may be required for the business to be conducted by Tenant on the Leased Premises will be granted, will continued in effect or renewed.

16.9 *Amendment.* This Lease may not be altered, amended or extended except by an instrument in writing signed by Tenant and Landlord. All negotiations, considerations, representations, and understandings between the parties are incorporated and merged herein, and may be modified or altered only by the

parties written agreement. This Lease represents the entire agreement of the parties with respect to the subject matter covered herein.

Landlord and Tenant have signed and sealed this Lease as of the day and year first above written.

LANDLORD:

Glenn Selbel

Doreen Selbel

TENANT:

Martha E Skelton, I
Skelton Family LLC

485

LEASE RENEWAL

This lease renewal shall commence on February 1, 2017. All terms and conditions of current lease dated February 1, 2007 shall remain in affect and continue in force along with addendums dated February 1, 2012 and December 23, 2015, with the following rent rates being the exception.

Rent of lease renewal shall be as follows:

Feb. 1, 2017 through Jan. 31, 2019	**$2,266.67 per month**
Feb. 1, 2019 through Jan. 31, 2021	**$2,333.34 per month**
Feb. 1, 2021 through Jan. 31, 2022	**$2,400.01 per month**

Additional NNN rent shall be paid of ~~$739.23~~ per month $649.53 ↔ $446 for Furnace deducted

Total rent for 1st and 2nd year per month shall be $3,005.90
Total rent for 3rd and 4th year per month shall be ~~$3,072.57~~ $3,028.17
Total rent for 5th year per month shall be ~~$3,139.24~~ 3,094.87

LANDLORD
Westminster, LLC

Glenn Seibel, Manager

TENANT
The Family Dentist, LLC

Alexander Smith, PhD DMD

4860

COMMERCIAL LEASE

This Commercial Building Lease is entered into this 6th day of September, 2018, between Westminster LLC, (Landlord), whose address is P.O. Box 926, Westcliffe, Co 81252 and Parkside Massage Therapy and /or Doris Paiz (owner), whose address is 4860 West 80th Ave., Westminster, Colorado 80030

1. Premises and Terms

1.1 Lease of Premises. Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, one thousand sq. ft. (front two thirds) of premises located at 4860 W. 80th Ave., Westminster, CO, together with all improvements including tow thirds of sidewalks and parking area, together with all personal property and fixtures thereon owned by Landlord (herein collectively "the Leased Premises")

1.2 Terms. This lease shall commence on December 1, 2018 (the "Commencement Date") and shall terminate five (5) years after Commencement Date, unless sooner terminated or extended as herein provided.

1.3 Options to Renew. Tenant shall have two options to extend this lease for five year terms at market rate. If Tenant wishes to exercise this option to extend, or declines this option, he shall deliver to Landlord written notice of his desires at least 90 days prior to the end of the existing lease.

1.4 Conditions of Premises. The Leased Premises are leased in an "as is" condition without any warranties or statements,. expressed or implied, as to physical or structural condition or merchantability or as to the suitability of the Leased Premises for Tenant's use as a professional office. Landlord shall not be responsible nor have any liability whatsoever at any time for losses or damage to Tenant's work or to fixtures, equipment, or other property of Tenant installed or placed by Tenant in the Leased Premises.

2. Rent

2.1 Monthly Rent. The term "rent" shall mean the amount set forth in this subparagraph. The first installment of rent (December Rent) shall be due and payable on the Commencement Date of this Lease by the Tenant. Thereafter, starting January 1, 2019 , each monthly installment of rent shall be due and payable on or before the first day of each calendar month during the term of this Lease. Tenant covenants and agrees to pay to Landlord rent as outlined below. Beginning on the third year and fifth year of this agreement the rent will increase on the anniversary of the Commencement Date as outlined below.

2.2 Rent. Rent for the first two years will be $750.00 per month. Beginning on the third year and through the fourth year the rent will increase to $775.00 per month. Beginning on the fifth year the rent will increase to $800.00 per month. One Hundred Dollars ($100.00) shall be deducted monthly from the monthly rent charge as reimbursement to tenant for maintenance of outside area of entire property.

2.3 No Set Off. Tenant waives and disclaims any present or future right to withhold any rent payment or other payment due under this Lease, or to set off in any action for rent, as a result of amy obligation of Landlord, however incurred, and agrees that hit will not claim or assert any right to so withhold or set off.

2.4 Late Charge. Any rental or other sums payable hereunder by Tenant which are not paid within ten(10) days after due shall bear interest from the due date to the date paid at the rate of eighteen percent (18%) per annum or the highest rate permitted by law, whichever is less. In addition to the above, Tenant shall pay Landlord a Seventy-five Dollar ($75.00) service charge for all monthly rent payments not paid by the tenth (10th) day of the month for which they are payable.

2.5 Utilities. Tenant shall pay to The Family Dentistry (or any other renter in whose name the utilities are billed), two thirds of those invoices submitted to them. These charges will include electric, water/sewer, and gas. Trash removal and telephone shall be the sole responsibility of tenant. Snow removal will be paid by tenant at one third the charge to The Family Dentistry (or any other renter in whose name the snow plowing is billed). All expenses shall be reimbursed within fifteen (15) days of receiving copies of these invoiced charges. If Tenant fails to pay any utilities or other expenses listed in this paragraph, Landlord shall have the right to pay the full amount due and this amount shall be an obligation of the Tenant to Landlord, payable on demand, and shall accrue interest as set forth in subparagraph 2.3.

2.6 Security Deposit. Tenant shall pay Landlord a security deposit in the amount of $750.00 upon the Commencement Date. The security deposit shall be held by the Landlord for the performance of Tenants covenants and obligations under this Lease, it being expressly understood that the security deposit shall not be considered an advance payment of rental or a measure of Landlord's damage in case of default by Tenant. Upon the occurrence of any event of default by Tenant or breach by Tenant of Tenant's covenants under this Lease, Landlord may from time to time and without prejudice to any other remedy, use the security deposit to the extent necessary to make good any arrears of rent, or to repair any damage or injury, or pay any expenses or liability incurred by Landlord as a result of the event of default or breach of covenant, and any remaining balance of the security deposit shall be returned by Landlord to Tenant within thirty (30) days after termination of this Lease. If any portion of the security deposit is so used or applied, Tenant shall upon ten(10) days written notice deposit with Landlord an amount sufficient to restore the security deposit to her original amount.

3. Permitted Uses

Permitted Uses. Leased Premises shall be for providing professional services that are agreed upon by the Landlord. Tenant shall not use the premises in a manner that is unlawful, creates damage, waste or a nuisance, or that disturbs occupants of or causes damage to neighboring premises or properties.

4. Construction/Improvements

4.1 Tenant Improvements. Tenant shall not make or allow to be made any alterations or physical additions in or to the Leased Premises without first obtaining the written consent of Landlord; (all such additional alterations and improvements are herein referred to as the "Tenant Improvements". Tenant Improvements shall be done in a workmanlike manner in accordance with industry standards and shall comply with all laws, ordinances, codes and regulations governing the Leased Premises and the construction of Tenant Improvements. Tenant shall pay contractors and laborers as well as materials for Tenant Improvements and not allow any mechanic's lien to arise which is not removed or bonded over within thirty (30) days of filing. Tenant shall indemnify, defend and hold Landlord harmless from and against any liability, loss, damage, and cost or expenses, including attorney's fees, on account of any claims or any nature, including claims of liens of labor or material or others for work performed for or materials or supplies furnished to Tenant or persons claiming under Tenant. All Tenant Improvements to the Leased Premises shall remain upon the Leased Premises and become the property of the Landlord upon expiration or termination of the Lease, unless such Tenant Improvements can be removed by Tenant without damage to the Leased Premises. Specifically, Tenant may remove the following items: All dental x-ray units and cabinetry purchased as equipment and not leasehold improvements and all trade fixtures.

4.2 Signage. Tenant may use signage affixed to current signage on approval of existing tenant or attach signage to building or affix vinyl lettering and graphics to glass windows or doors. All signage must first be approved by Landlord.

4.3 Removal of Tenant Improvements. All electronic, phone and data cabling and related equipment (collectively, "Cabling") shall be and remain the property of Tenant. Upon the expiration or earlier termination of this Lease, Tenant shall, at their sole expense , remove all such Cabling and repair any damage to the Leased Premises or the building caused by such removal. If Tenant fails to remove

covenants, and conditions hereof are in all respects subject and subordinate to all zoning restrictions affecting the Leased Premises, and Tenant agrees to be bound by such restrictions. Landlord does not warrant that any license or licenses, permits or permits, which may be required for the business to be conducted by Tenant on the Leased Premises will be granted, will continue in effect or renew.

16.9. Amendment. This lease may not be altered, amended or extended except by an instrument in writing signed by Tenant and Landlord. All negotiations, considerations, representations, and understandings between the parties are incorporated and merged herein, and may be modified or altered only by the parties written agreement. This Lease represents the entire agreement of the parties with respect to the subject matter covered herein.

Landlord and Tenant have signed and sealed this Lease as of the day and year first above written.

LANDLORD		TENANT	
	Dated 9-24-15	Doris Palz	Dated 9-24-15
Glenn Seibel, Manager Westminster, LLC		Doris Palz, Owner Parkside Massage Therapy	

Market Sales
Adjustment Grid

4850-60 W. 80th MktGrd xls x!sx

	Subject	Comp 1	Adj	Comp 2	
Use	Class C Office	Class C Office		Class C Office	
Address	4850 W. 80th Ave.	3901 W. 88th Ave		7145 Lowell Blvd.	
City	Westminster	Westminster		Westminster	
Sale Date		Nov-16		Dec-16	
Sale Price		$555,000		$349,900	
Condition of Sale		$0		$0	
Adj. Sale Price		$555,000		$349,900	
Adj.Price per Sq. Ft. (Gross)		**$126.14**		**$132.54**	
Comp Size: Rentable Sq. Ft.	2,970	4,400		2,640	
Land Size SF	24,829	17,424		11,761	
Building to Land Ratio	8.3%	3.96	[illegible]	4.45	5.0%
Year Built	1977	1962		1954	
Construction	Masonry	Frame		Masonry	
Location	Fair	Fair		Fair	
Quality	Good	Good		Good	
Condition(Functionality)	Good	Good		Good	
Total Adjustments			[illegible]		[illegible]
Adjusted $/SqFt	$135.40	$132.44		$139.16	
Indicated Value for Subject	$403,338	$393,356		$413,319	

1

3901 W 88th Ave

SOLD

Westminster, CO 80031
Sale on 11/15/2018 for $555,000 ($126.14/SF) - Research Complete
4,400 SF Class C Office Building Built in 1962

Buyer & Seller Contact Info

Recorded Buyer:	**Rrww Properties Llc**	Recorded Seller:	**Last Olive LLC**
True Buyer:	**Lakota Plumbing, Inc** **Roberta Wick** 7521 Xavier St Westminster, CO 80030 (303) 429-5118	True Seller:	**Last Olive LLC** **Blake Schreck** 10 Circle Dr Fort Collins, CO 80524 (303) 626-2622
		Seller Type:	**Other - Private**
Buyer Broker:	**Front Range Reality Pro** **Terry Travis** (303) 466-4663	Listing Broker:	**Vista Commercial Advisors** **Chris Jensen** (303) 974-7500

Transaction Details

ID: 3702832

Sale Date:	**11/15/2018 (208 days on market)**	Sale Type:	**Owner User**
Escrow Length:	**30 days**	Bldg Type:	**Office**
Sale Price:	**$555,000-Confirmed**	Year Built/Age:	**Built in 1962 Age: 54**
Asking Price:	**$572,000**	RBA:	**4,400 SF**
Price/SF:	**$126.14**	Land Area:	**0.40 AC (17,424 SF)**
Price/SF Land Gross:	**$31.85**		
Percent Leased:	**100.0%**		
Tenancy:	**Single**	Percent Improved:	**63.9%**
		Total Value Assessed:	**$84,600 in 2015**
		Improved Value Assessed:	**$54,060**
		Land Value Assessed:	**$30,540**
		Land Assessed/SF:	**$1.00**
No. of Tenants:	**1**		
Tenants at time of sale:	**Anne Schreck**		
Financing:	**Down payment of $83,300.00 (15.0%)** **$471,700.00 from US Bank**		
Legal Desc:	**Track A blk 1 Shaw Heights**		
Parcel No:	**1719-19-4-13-033**		

3 7145 Lowell Blvd

SOLD

Westminster, CO 80030
Sale on 12/9/2016 for $349,900 ($132.54/SF)
2,640 SF Class C Office Building Built in 1954

Buyer & Seller Contact Info

Recorded Buyer:	**West Gate Properties LLC** 7251 Vrain St Westminster, CO 80030	Recorded Seller:	**Answer All Secretarial**
True Buyer:	-	True Seller:	**Answer All Secretarial** **Gwen Corbett** 7145 Lowell Blvd Westminster, CO 80030 (970) 330-3607
		Listing Broker:	**Pieters Realty** **James Pieters** (303) 438-0881

Transaction Details

ID: 3777311

Sale Date:	**12/09/2016 (441 days on market)**	Sale Type:	**Owner User**
Escrow Length:	**30 days**	Bldg Type:	**Office**
Sale Price:	**$349,900-Confirmed**	Year Built/Age:	**Built in 1954 Age: 62**
Asking Price:	**$349,900**	RBA:	**2,640 SF**
Price/SF:	**$132.54**	Land Area:	**0.27 AC (11,761 SF)**
Price/SF Land Gross:	**$29.75**		
Percent Leased:	**100.0%**		
Transfer Tax:	**$34.99**		
Financing:	**Down payment of $87,475.00 (25.0%)**		
Parcel No:	**1825-06-1-00-006**		
Document No:	**0109582**		
Sale History:	**Sold on 4/26/2017** **Sold for $349,900 ($132.54/SF) on 12/9/2016**		

1st Net Real Estate Services, Inc., 3333 S. Wadsworth Blvd. Ste D-105
Lakewood, CO 80227 • Phone: 720-962-5750 • Fax: 720-962-5760 • Web: 1stnetre.com

March 5, 2020

Adams County Assessor's Office
4430 S. Adams County Parkway
5th Floor Suite C5000A
Brighton CO 80601-8204

Re: 4850 W. 80th Ave. Account# R0064210

To All Parties Concerned:

I have enclosed a Petition for Abatement for the tax year of 2019 for the above mentioned property.

Thank you

Dan George
1st Net Real Estate Services, Inc.

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

COUNTY BOARD OF EQUALIZATION

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0100719 Parcel N0.(S) 01825-05-4-05-009

2. The subject property is classified as a Residential property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$105,000
Improvements	$812,937
Total	$917,937

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$105,000
Improvements	$570,000
Total	$675,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: August 3, 2020

Phyllis A. Persinger

Petitioner's Representative
Phyllis A Persinger
2810 W 65th Place
Denver, CO 80221

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0100719 Parcel No : 01825-05-4-05-009
Petition Year : 2019 Date submitted: July 2, 2020
Owner Entity : Robert B Olivas and Phyllis A Persinger
Owner Address : 2810 W 65th Place
Owner City : Denver State : CO, 80221
Property Location : NORTH LAWN GARDENS BLK: 2 LOT: 9

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	100	L: $105,000	$7,508	L: **$105,000**	**$7,510**	A. Ratio	7.15%
		I: $539,237	$38,555	I: **$812,937**	**$58,120**	Mill Levy	122.420
TOTALS :		**$644,237**	**$46,063**	**$917,937**	**$65,630**	Original Tax	**$8,034.42**

Petitioner's Statement :

The owner provided no comments on the petition. However, a Realtor provided a letter indicating the square footage was not correct as well as issues pertaining to the location of the subject. The subject is in close proximity to a mobile home park as well as about 1.5 blocks east of Federal Blvd. The letter from the realtor is on file.

Assessor's Report

Situation :

The subject property is a two story three unit property. The property has 19,602 sq ft lot. The home has a total of 15 rooms, 6 bedrooms and 4 bathrooms. The owner lives on site in the unit above the garage. The garage is very large and includes a 3/4 bath and laundry area. There is a single car garage door on the east site of the main level of the home. There are two detached garages (1 car and a 2 car) that are in poor condition and not useable as a garage. No value given to these two buildings. It is noted that the owner occupies one of the three units.

Action :

The subject property was inspected on 7.27.2020 at 9am. The individual units were not inspected per the owner request; however, the interior of the garage was inspected. The building was measured as well as the garage to get a more accurate square footage of the improvements. The property was in average condition.

Recommendation :

Upon further review, a reduction in value appears warranted. **PLEASE NOTE: THE OWNER HAS THE SENIOR EXEMPTION.**

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	100	L: **$105,000**	**$7,510**	L: **$105,000**	**$7,510**	Tax Refund	**$2,125.21**
		I: **$812,937**	**$58,120**	I: **$570,000**	**$40,760**	Revised Tax	**$5,909.21**
TOTALS :		**$917,937**	**$65,630**	**$675,000**	**$48,270**		

Eric I Norberg August 3, 2020

Eric I Norberg Date
Residential Appraiser III, Adams County Assessor's Office
Colorado Licensed Appraiser AL01323002

PETITION FOR ABATEMENT OR REFUND OF TAXES

RECEIVED

County: Adams

Date Received _____
(Use Assessor's or Commissioners' Date Stamp)

JUL 0 2 2020

OFFICE OF THE
ADAMS COUNTY ASSESSOR

Section I: Petitioner, please complete Section I only.

Date: 7 (Month) 2 (Day) 2020 (Year)

Petitioner's Name: Robert B. Olivas and Phyllis A. Persinger

Petitioner's Mailing Address: 2810 W. 65th Place

Denver (City or Town) CO (State) 80221 (Zip Code)

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
R0100719	2810 W. 65th Place Denver CO

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

Petitioner's estimate of value: $644,237 (Value) (2019) (Year)

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Phyllis A. Persinger
Petitioner's Signature

Daytime Phone Number (303) 910-3789

Email possum6787@yahoo.com

By: Robert B Olivas
Agent's Signature*

Daytime Phone Number (___) [redacted]

Printed Name: _____

Email _____

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: Assessor's Recommendation
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

RECEIVED

_____
Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/17

JUL 0 2 2020

OFFICE OF THE
ADAMS COUNTY ASSESSOR

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature **Date**

_____ _____
Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

Adams County Assessor
4430 S Adams County Pkwy C2100
Brighton, CO 80601

Presorted
First Class Mail
U.S. Postage
PAID
Permit #4033
Denver, CO

2019 REAL PROPERTY VALUATION INSIDE
This is not a tax bill

T94 P1 165 53992

**********AUTO**5-DIGIT 8022
OLIVAS ROBERT B AND PERSINGER PHYLLIS A
2810 W 65TH PL
DENVER CO 80221-2210

2019 REAL PROPERTY PROTEST FORM

The options to file an appeal are: online at www.adcogov.org/assessor, complete the form and mail/fax it to the Assessor, email the form to the Assessor at assessor@adcogov.org or appeal in person at **Adams County Assessor, 4430 S. Adams County Pkwy, Brighton, CO 80601** by June 3, 2019.

ACCOUNT NUMBER: R0100719

PROPERTY OWNER: OLIVAS ROBERT B AND PERSINGER PHYLLIS A

TO APPEAL ACCOUNT R0100719 CHECK HERE ☒

YOUR REASON FOR APPEALING VALUE IS: See attached paperwork and realtor's letter

Please attach additional information if necessary.

I, the undersigned owner or agent of the property identified above, affirm that the statements contained herein and on any attachments hereto, are true and complete.

Phyllis A. Persinger Robert B. Olivas 303-910-3789 6-8-2020
Signature Telephone Number Date

possum67870@yahoo.com
E-Mail Address

AGENT AUTHORIZATION: You must provide written authorization if you are using an agent. The agent's name, mailing address, e-mail address, and telephone number must be provided.

YOUR RIGHT TO APPEAL THE PROPERTY VALUATION AND/OR THE CLASSIFICATION TO THE ASSESSOR EXPIRES JUNE 3, 2019

If the date for filing any document falls upon a Saturday or legal holiday, it shall be deemed timely filed if postmarked or received on the next business day. 39-1-120(3). C.R.S.

2019 REAL PROPERTY NOTICE OF VALUATION

In order to save postage and printing costs, this is a condensed version of your Notice of Valuation. See your entire Notice of Valuation including a listing of the characteristics of your property that are germane to value, further details on the protest and appeals process, sales data for researching your valuation and an online protest filing application on our website at www.adcogov.org/assessor.

Account	Property Address/Description	Access key
R0100719	2810 W 65TH PL #1 SUB:NORTH LAWN GARDENS BLK:2 LOT:9	157344887985

****IMPORTANT**- You must have the information on this postcard to appeal online.**

Classification	Prior	Current	Difference
RESIDENTIAL	506,381	917,937	+411,556
Land 105,000 Building 812,937			
TOTAL	506,381	917,937	+411,556

For appeals involving more than one account, please submit by mail or in person.
If you are unable to view your Notice of Valuation online, please call us at (720) 523-6038.
Seniors 65 and over who have lived in their home for over 10 years and Disabled Veterans may qualify for a property tax exemption. Visit the Assessor's website at www.adcogov.org/assessor or call (720) 523-6038 for more information.

_____

_____

_____

☐ Check here if new address

Place stamp here.
Post Office will not deliver mail without proper postage.

ADAMS COUNTY ASSESSORS OFFICE
4430 S ADAMS COUNTY PKWY STE C2100
BRIGHTON CO 80601-8201

CORRECTIONS TO ADAMS COUNTY PUBLIIC RECORDS

2810 W. 65th Place
Unincorporated Adams County
Denver CO 80221
Account No: R0100719
Owner: Olivas, Robert B.
Persinger, Phyllis A.

	Current	Correction
Lot Size:	0.45 Acre	0.45 Acre
Type of Building:	Duplex/Triplex (Owners live in Unit #3)	Triplex
Number of Stories:	One	Two
Rooms:	15 (counting bathrooms	15 (same
Baths:	3	4
Bedrooms:	9	6
Heat:	Forced Air Heat	Hot Water Heat
Cooling:	Central	Window A/Cs

Phyllis Persinger

RECEIVED

JUL 02 2020

OFFICE OF THE
ADAMS COUNTY ASSESSOR

2810 W 65th Pl #1, Denver, CO 80221-2210, Adams County

Subject

9	4,336	19,602	N/A
Beds	Bldg Sq Ft	Lot Sq Ft	Sale Price
3	1986	DUPLEX	N/A
Baths	Yr Built	Type	Sale Date

Owner Information

Owner Name:	**Olivas Robert B**	Mailing Zip:	**80221**
Owner Name 2:	**Persinger Phyllis A**	Mailing ZIP 4:	**2210**
Mailing Address:	***2810 W 65th Pl***	Mailing Carrier Route:	**C012**
Mailing City & State:	**Denver, CO**	Owner Occupied:	**Yes**

Location Information

Property Zip:	**80221**	Census Tract:	**95.02**
Property Zip4:	**2210**	Neighborhood Code:	**Unincorporated Adams-200**
Property Carrier Route:	**C012**	Neighborhood Name (OnBoard):	**Stites Mobile Home Community**
School District:	**Westminster Pub Schl**	Township:	**03S**
Elementary School:	**F. M. Day**	Range:	**68W**
Middle School:	**Scott Carpenter**	Section:	**05**
High School:	**Westminster**	Quarter:	**SE**
Subdivision:	***North Lawn Gardens***	Block:	**2**
Zoning:	**R-2**	Lot:	**9**

Tax Information

PIN:	**R0100719**	% Improved:	**89%**
Alternate PIN:	**1825-05-4-05-009**	Tax District:	**495**
Schedule Number:	**R0100719**		
Legal Description:	**SUB:NORTH LAWN GARDENS BLK:2 LOT:9**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$105,000	$90,000	$90,000
Market Value - Improved	*$812,937*	*$416,381*	*$416,381*
Market Value - Total	$917,937	$506,381	$506,381
Assessed Value - Land	$7,510	$6,480	$6,480
Assessed Value - Improved	$58,120	$29,980	$29,980
Assessed Value - Total	$65,630	$36,460	$36,460
YOY Assessed Change (%)	80.01%	0%	
YOY Assessed Change ($)	$29,170	$0	

Tax Year	Total Tax	Change ($)	Change (%)
2017	$3,177		
2018	$3,623	$447	14.06%
2019	$7,159	$3,536	97.58%

Characteristics

Lot Frontage:	**98**	Bldg Sq Ft - 2nd Floor:	**2,320**
Lot Depth:	**200**	# Buildings:	**1**
Lot Acres:	**0.45**	Total Rooms:	**15**
Lot Sq Ft:	**19,602**	Bedrooms:	**9**
Lot Shape:	**Dxt**	Baths - Total:	**3**

Property Detail

Land Use - County:	**Duplex/Triplex**	Baths - Full:	**3**
Land Use - CoreLogic:	**Duplex**	Stories:	**1**
Building Type:	**Triplex**	Cooling Type:	**Central**
Style:	**Duplex**	Heat Type:	**Forced Air**
Year Built:	**1986**	Garage Type:	**Carport**
Bldg Sq Ft - Above Ground:	**4,336**	Roof Material:	**Composition Shingle**
Bldg Sq Ft - Total:	**4,336**	Construction:	**Frame**
Bldg Sq Ft - Finished:	**4,336**	Exterior:	**Frame**
Bldg Sq Ft - 1st Floor:	**2,016**	Quality:	**Average**

Features

Feature Type	Size/Qty
Allowance	3
Bath 4	3
Gable	250
Open Slab	432
Second Floor	2,320
First Floor	2,016

Building Description	Building Size
Duplex	1

Estimated Value

Value As Of: **05/28/2020**

Last Market Sale & Sales History

Owner Name:	**Olivas Robert B**	Owner Name 2:	**Persinger Phyllis A**

Sale Date	01/21/1999	11/19/1990	12/15/1986
Sale Price		$6,000	
Nominal	Y	Y	Y
Buyer	Olivas Robert B	Olivas Robert B	Olivas Robert B
Seller	Olivas Robert B	Olivas Robert B & Olivas A H J	Olivas Robert B
Document Number	5629-144	3735-108	3264-561
Document Type	Quit Claim Deed	Quit Claim Deed	Quit Claim Deed
Title Company	Land Title Insurance Co.		

Mortgage History

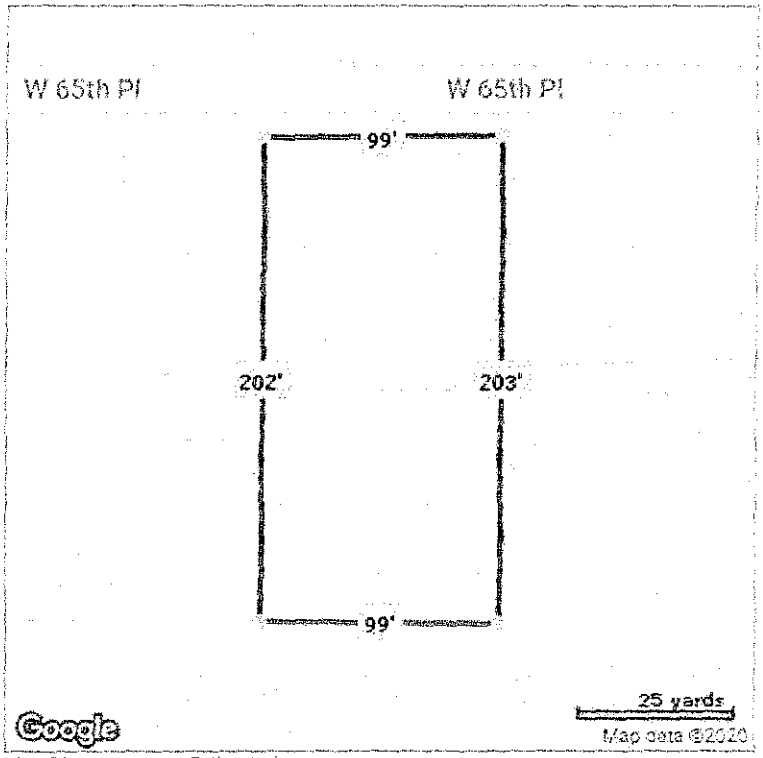
Mortgage Date	03/07/2016	09/07/2012	11/19/2007	02/26/2003	07/11/2001
Mortgage Amount	$10,000	$173,200	$25,000	$180,000	$28,350
Mortgage Lender	Vectra Bk/Co	Vectra Bk/Co Na	Vectra Bk/Co Na	Vectra Bk/Co Na	Vectra Bk/Co Na
Borrower	Olivas Robert B	Olivas Robert B	Olivas Robert B	Olivas Robert B	Olivas Robert
Borrower	Persinger Phyllis A	Persinger Phyllis A	Persinger Phyllis A	Persinger Phyllis A	
Mortgage Type	Conventional	Conventional	Conventional	Conventional	Conventional
Mortgage Purpose	Refi	Refi	Refi	Refi	Refi
Mortgage Int Rate Type	Adjustable Int Rate Loan		Adjustable Int Rate Loan	Fixed Rate Loan	
Mortgage Term	30	30	30	30	15
Mortgage Term	Years	Years	Years	Years	Years
Title Company	Indecomm Global Svcs	Stewart Title	United General Title Insurance	Security Title Co	

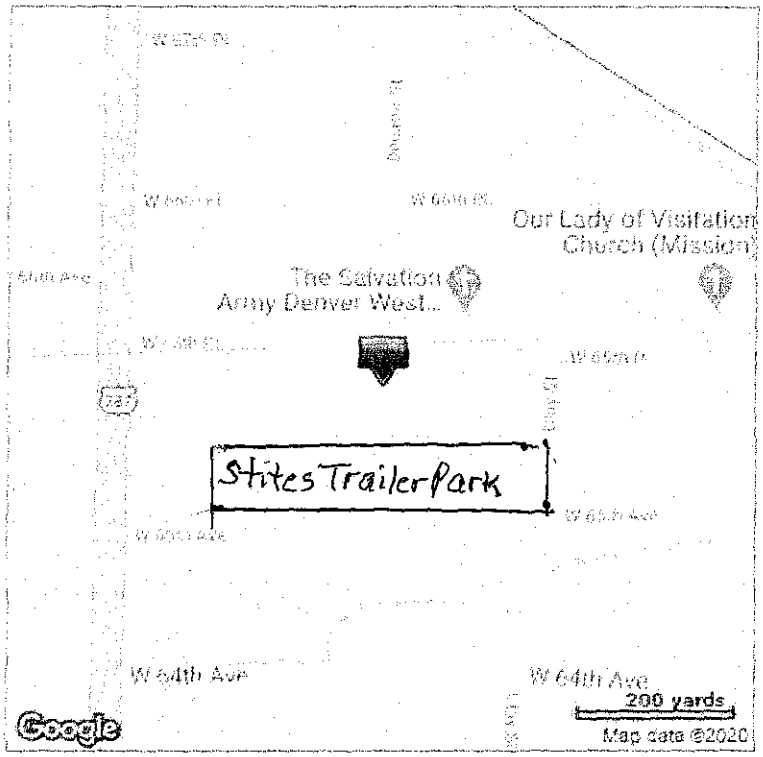
Mortgage Date	01/26/2001	09/29/1999	09/16/1999
Mortgage Amount	$177,000	$167,000	$5,415
Mortgage Lender	Vectra Bk/Co Na	Vectra Bk/Co Na	Norwest Hm Improvement Inc
Borrower	Olivas Robert B	Olivas Robert B	Olivas Robert B
Borrower			
Mortgage Type	Conventional	Conventional	Conventional
Mortgage Purpose	Refi	Refi	Refi
Mortgage Int Rate Type			

Property Detail

Mortgage Term	30	
Mortgage Term	Years	
Title Company	Wasatchland Title	Land Title Insurance Co.

Property Map





*Lot Dimensions are Estimated

Criteria Map Results

0 of 110 Checked 0 All · None · Page · Jump to Address

Property Type is 'Residential Income'
Mls Status is 'Active'
Originating System Name is one of 'REcolorado', 'REcolorado (ROCC)', 'REcolorado (SSBR)'
Ordered by Mls Status, Standard Status, Current Price descending, Originating System Name descending
Found 110 results in 0.16 seconds.

↑ Trailer park behind 2810 W. 65th Place

R0100744, Denver, CO, Adams County

Typical of Industrial in AREA

N/A	N/A	17,400	N/A
Beds	Bldg Sq Ft	Lot Sq Ft	Sale Price
N/A	N/A	COM-NEC	N/A
Baths	Yr Built	Type	Sale Date

Owner Information

Owner Name:	**Webb Frederick R**	Mailing Zip:	**80212**
Mailing Address:	**Po Box 12010**	Mailing ZIP 4:	**0010**
Mailing City & State:	**Denver, CO**	Mailing Carrier Route:	**B001**

Location Information

Property Zip:	**80221**	Neighborhood Code:	**Commercial-5**
School District:	**Westminster Pub Schl**	Township:	**03S**
Elementary School:	**F. M. Day**	Range:	**68W**
Middle School:	**Scott Carpenter**	Section:	**05**
High School:	**Westminster**	Quarter:	**SE**
Subdivision:	**North Lawn Gardens**	Block:	**2**
Zoning:	**C-5**	Lot:	**1**
Census Tract:	**95.02**		

Tax Information

PIN:	**R0100744**	Schedule Number:	**R0100744**
Alternate PIN:	**1825-05-4-05-039**	Tax District:	**495**
Legal Description:	**SUB:NORTH LAWN GARDENS BLK:2 DESC: LOT 1 EXC S 16/5 FT OF W 160 FT**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$139,200	$139,200	$139,200
Market Value - Total	$139,200	$139,200	$139,200
Assessed Value - Land	*$40,370*	*$40,370*	*$40,370*
Assessed Value - Total	$40,370	$40,370	$40,370
YOY Assessed Change (%)	0%	0%	
YOY Assessed Change ($)	$0	$0	

Tax Year	**Total Tax**	**Change ($)**	**Change (%)**
2017	$4,383		
2018	$4,999	$616	14.06%
2019	$4,942	-$57	-1.14%

Characteristics

Lot Acres:	**0.3994**	Land Use - County:	**Misc Commercial Land**
Lot Sq Ft:	**17,400**	Land Use - CoreLogic:	**Commercial (NEC)**

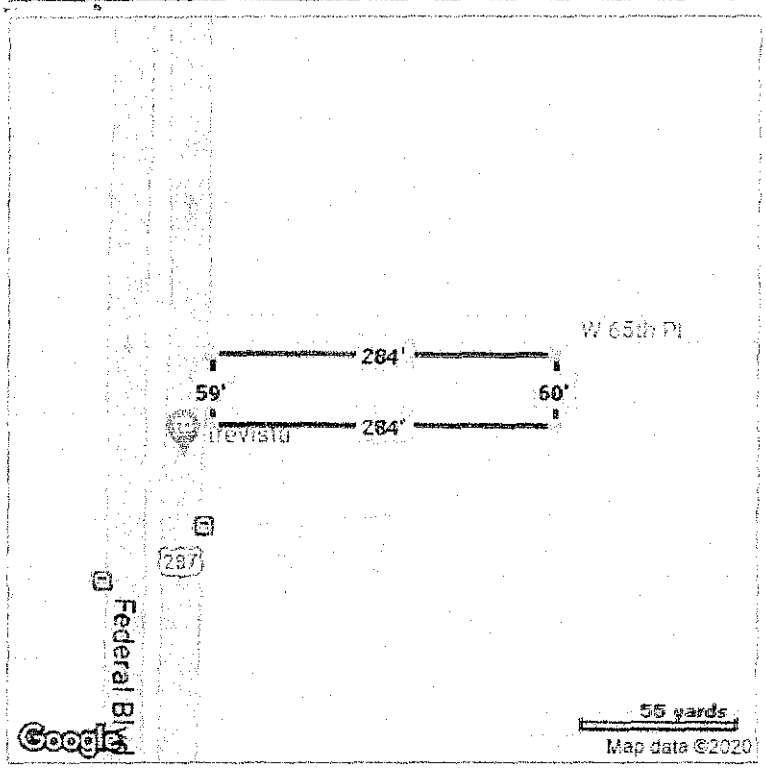
Estimated Value

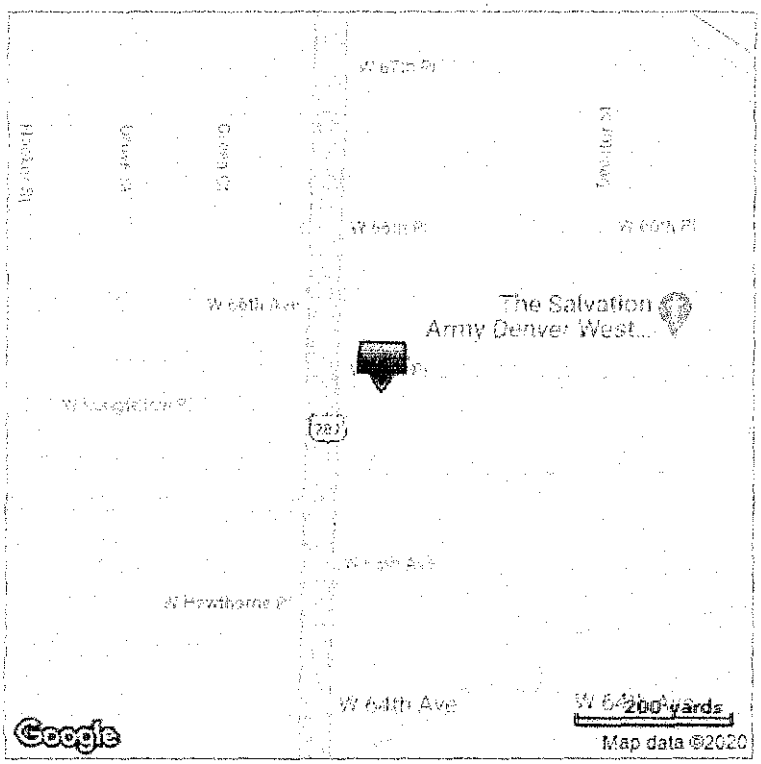
Value As Of:	**05/28/2020**

Last Market Sale & Sales History

Owner Name:	**Webb Frederick R**

Property Map





*Lot Dimensions are Estimated

Redfin Estimate for 2810 W 65th Pl #1

Edit Home Facts to improve accuracy.

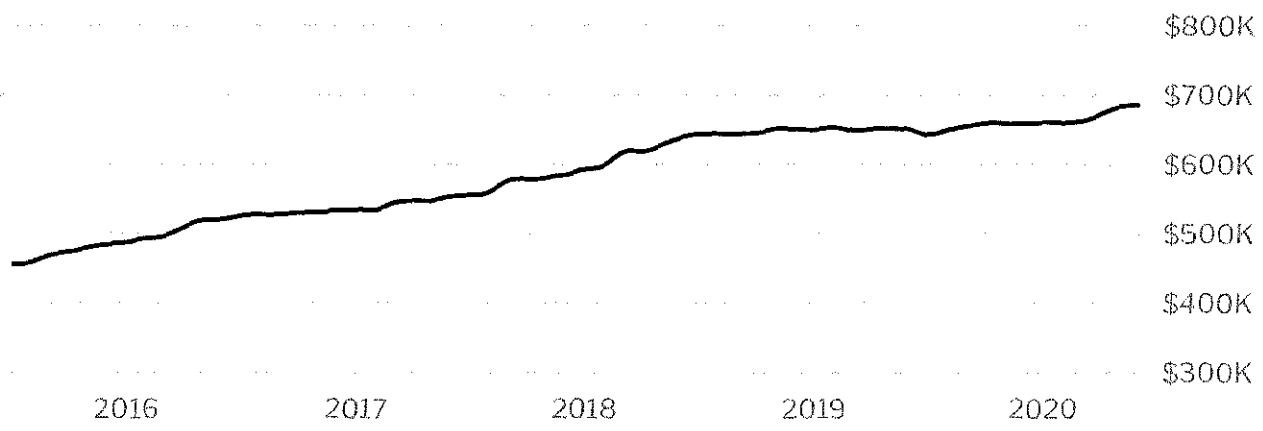
Create an Owner Estimate

$686,419

Track This Estimate

June 2020

1 year 5 years



Redfin Estimate based on recent home sales.

Homeowner Tools

Edit home facts

Review property details and add renovations.

Movoto ★ ★ ★ ★ ★
Denver Agent

I'm happy to give you a quick call to answer all your questions about this home and schedule a tour, in person or virtually.

Full Name

Email

Phone

We'll call you within the next business hour. Click to consent to receive text messages, calls (direct, autodialed, or prerecorded even if on the Do Not Call list) and/or emails from Movoto or our partner. Consent is not required to receive Real Estate services.

Get In Touch

Edgewater	[illegible]	[illegible]
Wheat Ridge	4.51	12
Commerce City	4.67	12

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arvada, colorado 80004
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cs&associates

May 20, 2020

To whom it may concern,

I'm writing in behalf of my clients Phyllis Persinger and Robert Olivas for whom I currently manage an investment property. The address of said property is 2810 W. 65th Place, Denver, CO 80221.

I have been made aware of the recent tax assessment on the property and have been asked to give my professional opinion on the value of the home.

When I looked at the tax records for this home, I noticed that the square footage does not seem to be correct as well as the number of bedrooms. The three units each have 2 bedrooms and a bathroom so there are only 6 bedrooms total. The combined square footage for the front 2 units is about 1500, so that leaves the back unit at 2800 square feet which is obviously incorrect. We have managed this property for close to 20 years and are very familiar with the area and condition of the property and can strongly suggest that the current assessment is unduly influenced by the inflated Colorado market as well as a slew of newer homes being built in the area.

If taken into consideration the condition of the property and the average price per square foot of homes built in the area, excluding the recent newly built homes which are in a different bracket, I would feel the value of the home to be about $700,000.00.

My client has reached out to us in the past about possibly selling the home and asking for a possible value and we have never felt confident to list this home for anywhere close to what it is currently being assessed at. We have never had the home appraised, but I would imagine it would not appraise for close to the current assessed price as well.

I believe this assessment is mistakenly high due to a number of factors. Therefore, I have advised my client to get an appraisal done and to submit a formal notice of protest as they also feel the assessment is too high.

Thank you,

Jody Beckstead

CS & Associates Properties

Sonja Arney Properties
SONJA ARNEY • BROKER/OWNER

June 8, 2020

To: Adams County Assessor's Office

From: Sonja Arney/Sonja Arney Properties
Robert B Olivas and Phyllis A Persinger -Property Owners
Subject: Appeal on Tax Assessment

Respected Sir,

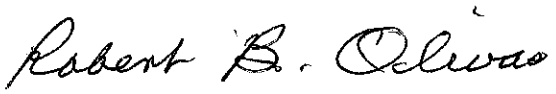
A tax assessment was conducted by your department on our property recently on the dated in January 2020 and additionally the 2019 Real Property Notice of Valuation report that I received on May of 2020. There are considerable mistakes in tax assessment relative to the stats of the property, and I would like to appeal against the assessment.

According to the report, the total worth of my assessments is shown to be $901793. But should be less even than the previously assessed amount of $722471 which is indicated in the attached documentation. There are several other errors in the county's information on our property. This is a triplex and not a duplex and has 6 bedrooms not 8 bedrooms. Not to mention that the property is in a highly industrialized area among several other rental properties much larger than our property and industrial business locations within walking distance in the same block. Directly across the street as well as next door there are commercial properties. Because of these differences, the tax to be paid by me is a much higher value than the exact sum I should pay. I have enclosed all the supporting documents that support this claim. That documentation illustrates numerous similar properties in the Denver Metro that are in much more desirable locations and with assessment values considerably lower than the assessment placed on our property by Adams County. I request to make a re-evaluation of the assessment and make the necessary changes.

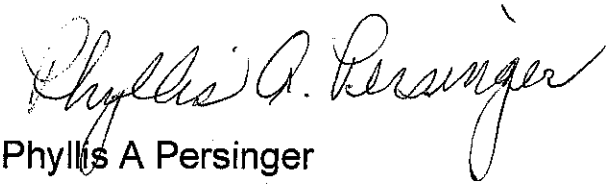
Additionally, only two of the units in our property are rental locations as we occupy the third unit. Thus, the income on this property is only for two units.

Regards,

Sonja Arney/Sonja Arney Properties/Broker



Robert B Olivas



Phyllis A Persinger

Sonja Arney
SRES, SSC, REO Specialist, Realtor
Sonja Arney Properties
https://www.sonjaarneyproperties.com/
Serving Denver Metro and Front Range
Direct: 303-250-6008

Please view the comparable properties located within the block of the subject property.

A range of property evaluations for remarkably similar types of properties. The subject property value and assessment is much higher that the similar properties.

Note the industrial nature of the surrounding area. (Picture)

Also included are similar properties of the Denver and surrounding areas. These properties are in much more desirable areas with much lower assessment values.

Additionally, there are three properties that have been used for comparables for the subject property illustrating a disparity in assessment.

2910 W 65th Pl, Denver, CO 80221-2236, Adams County

Comp 1

8	3,300	19,600	$285,000
MLS Beds	MLS Sq Ft	Lot Sq Ft	Sale Price
4	1958	MLT FAM <10	12/17/2001
MLS Baths	Yr Built	Type	Sale Date

Expired Listing

Owner Information

Owner Name:	**Kndv Verhey LLC**	Mailing ZIP 4:	**5017**
Mailing Address:	**6115 W 63rd Ave**	Mailing Carrier Route:	**C004**
Mailing City & State:	**Arvada, CO**	Owner Occupied:	**No**
Mailing Zip:	**80003**		

Location Information

Property Zip:	**80221**	Census Tract:	**95.02**
Property Zip4:	**2236**	Neighborhood Code:	**North Central Adams County-65**
Property Carrier Route:	**C012**	Neighborhood Name (OnBoard):	**Stites Mobile Home Community**
School District:	**Westminster Pub Schl**	Township:	**03S**
Elementary School:	**F. M. Day**	Range:	**68W**
Middle School:	**Scott Carpenter**	Section:	**05**
High School:	**Westminster**	Quarter:	**SE**
Subdivision:	**North Lawn Gardens**	Block:	**2**
Zoning:	**R-2**	Lot:	**4**

Tax Information

PIN:	**R0100714**	% Improved:	**83%**
Alternate PIN:	**1825-05-4-05-004**	Tax District:	**495**
Schedule Number:	**R0100714**		
Legal Description:	**SUB:NORTH LAWN GARDENS BLK:2 LOT:4**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$98,000	$98,000	$98,000
Market Value - Improved	$479,500	$255,394	$255,394
Market Value - Total	$577,500	$353,394	$353,394
Assessed Value - Land	$7,010	$7,060	$7,060
Assessed Value - Improved	$34,280	$18,390	$18,390
Assessed Value - Total	$41,290	$25,450	$25,450
YOY Assessed Change (%)	62.24%	0%	
YOY Assessed Change ($)	$15,840	$0	

Tax Year	Total Tax	Change ($)	Change (%)
2017	$2,763		
2018	$3,152	$389	14.06%
2019	$5,055	$1,903	60.39%

Characteristics

Lot Acres:	**0.45**	Baths - Total:	**4**
Lot Sq Ft:	**19,600**	MLS Total Baths:	**4**
Land Use - County:	**Multi-Unit 4-8 Unit**	Baths - Full:	**4**
Land Use - CoreLogic:	**Multi Family 10 Units Less**	Stories:	**1**

Property Detail

Nominal	Y	
Buyer	Bovaird Russell Allen	Bovaird Russell A
Buyer		
Seller	Bovaird Russell A & Mary Ann	Crotty Leo E
Document Number	4155-434	2944-767
Document Type	Quit Claim Deed	Warranty Deed
Title Company		

Mortgage History

Mortgage Date	08/09/2012	01/27/2003	12/26/2001	08/08/1994	09/23/1993
Mortgage Amount	$219,623	$257,941	$260,347	$64,450	$59,500
Mortgage Lender	First Option Lndg	Advantage Plus Mtg LLC	Jr Mtg Corp	Fbs Mtg Corp	Fbs Mtg Corp
Borrower	Verhey Nickolas B	Verhey Nickolas B	Verhey Nickolas	Poirier Leonard B	Bovaird Russell Allen
Borrower	Verhey Jennifer J	Verhey Jennifer	Verhey Jennifer	Poirier Mary Ann	
Mortgage Type	Fha	Fha	Fha	Conventional	Conventional
Mortgage Purpose	Nominal	Refi	Resale	Resale	Nominal
Mortgage Int Rate		6	7		
Mortgage Int Rate Type		Fixed Rate Loan			
Mortgage Term	30	30	30		
Mortgage Term	Years	Years	Years		

Mortgage Date	12/07/1984
Mortgage Amount	$21,200
Mortgage Lender	
Borrower	Bovaird Russell A
Borrower	
Mortgage Type	Private Party Lender
Mortgage Purpose	Seller/Carry Back
Mortgage Int Rate	
Mortgage Int Rate Type	
Mortgage Term	
Mortgage Term	

Building Type:	**Multi Family**	Cooling Type:	**Central**
Year Built:	**1958**	Heat Type:	**Forced Air**
Bldg Sq Ft - Above Ground:	**3,300**	Roof Material:	**Composition Shingle**
Bldg Sq Ft - Total:	**3,300**	Construction:	**Frame**
Bldg Sq Ft - Finished:	**3,300**	Exterior:	**Frame**
# Buildings:	**1**	Foundation:	**Concrete**
Total Rooms:	**16**	Quality:	**Average**
Bedrooms:	**8**	Equipment:	**Whe**

Features

Feature Type	Size/Qty
Avgunitsz	825
Open Slab	100
Acctsf	3,300
Allowance	4
Wood Roof	100
Open Slab	90
Open Slab	192
Uncovered Balcony	192
Water Heater	4
Bath 4	4

Building Description	Building Size
Apt 4-8 Units	1

Estimated Value

Value As Of: **05/28/2020**

Listing Information

MLS Listing Id:	**6644488**	MLS Original List Price:	**$595,000**
MLS Days On Market:	**29**	MLS Listing Contract Date:	**05/31/2018**
MLS Status:	**Expired**	MLS List Office Name:	**HAPPY HOMES REAL ESTATE**
MLS Status Change Date:	**10/17/2018**	MLS List Agent Full Name:	**026115-Jennifer Verhey**
MLS Current Price:	**$543,000**		

MLS Listing #	5906428	7145310	1124891
MLS Status	Expired	Expired	Expired
MLS Listing Price	$944,000	$385,000	$295,000
MLS Orig Listing Price	$944,000	$385,000	$295,000
MLS Listing Date	05/22/2018	01/30/2015	08/30/2012
MLS Listing Expiration Date	10/17/2018	06/30/2015	03/31/2013

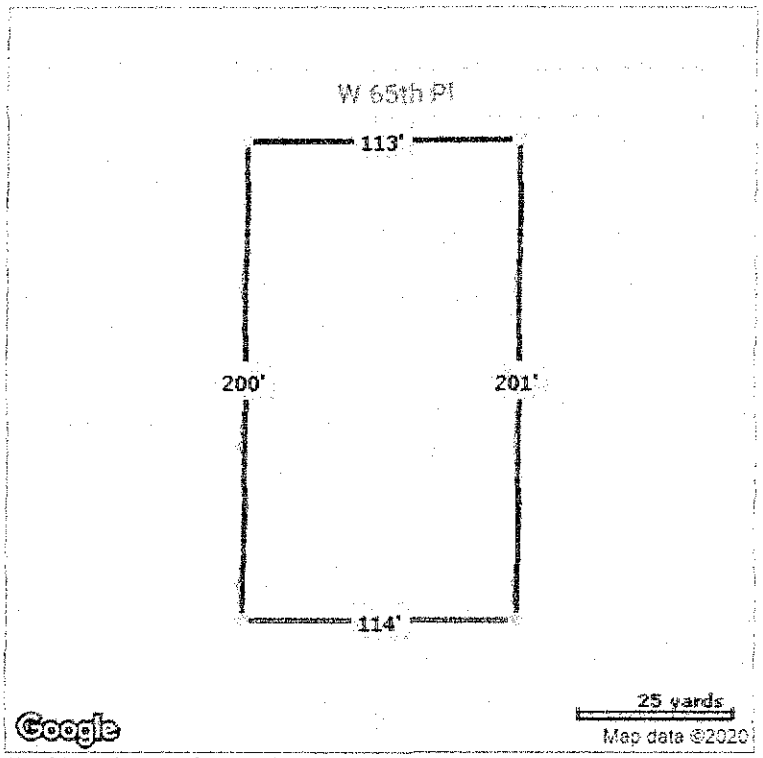
Last Market Sale & Sales History

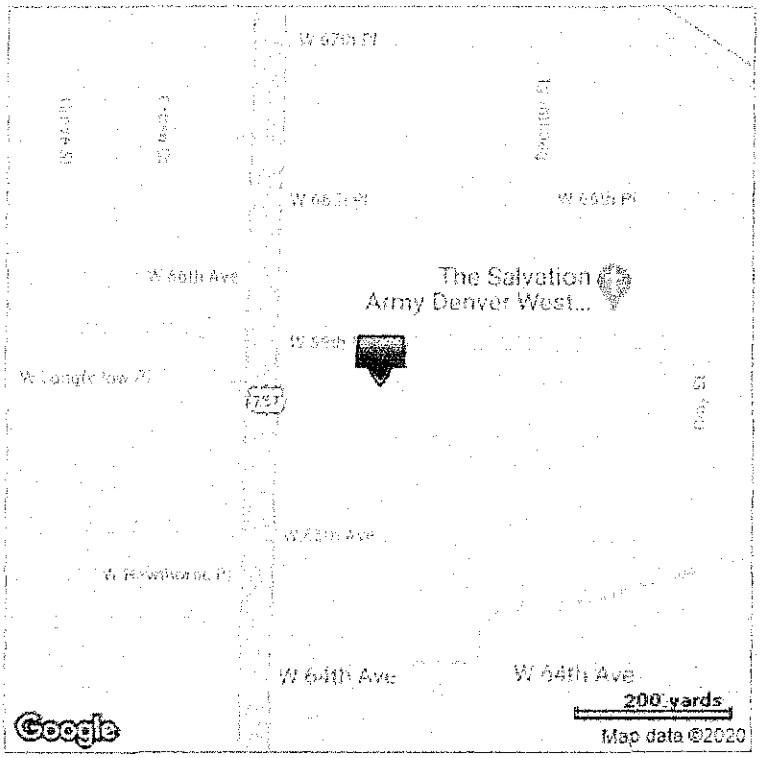
Sale Date:	**12/17/2001**	Sale Type:	**Full**
Sale Price:	**$285,000**	Deed Type:	**Warranty Deed**
Price per SqFt - Finished:	**$86.36**	Owner Name:	**Kndv Verhey LLC**
Document Number:	**C0904850**	Seller:	**Poirier Leonard B & Mary A**

Sale Date	08/07/2012	07/25/2012	05/02/2006	12/17/2001	08/04/1994
Sale Price				$285,000	$92,100
Nominal	Y	Y	Y		
Buyer	Kndv Verhey LLC	Verhey Nickolas B & Jennifer J	Kndv Verhey LLC	Verhey Nickolas & Jennifer	Poirier Leonard B & Mary Ann
Buyer		Verhey Jennifer J		Verhey Jennifer	Poirier Mary Ann
Seller	Verhey Nickolas B & Jennifer J	Kndv Verhey LLC	Verhey Nickolas & Jennifer	Poirier Leonard B & Mary A	Bovaird Russell Allen
Document Number	90158	58586	629860	C0904850	4370-175
Document Type	Quit Claim Deed	Quit Claim Deed	Quit Claim Deed	Warranty Deed	Warranty Deed
Title Company		First Integrity Title		Transnation Title Ins Co	

Sale Date	09/10/1993	
Sale Price		$120,000

Property Map

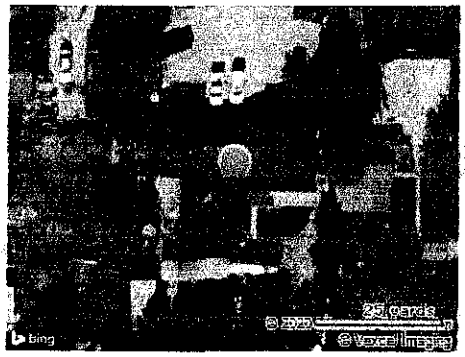




*Lot Dimensions are Estimated

2860 W 65th Pl, Denver, CO 80221-2210, Adams County

Comp #2



5	2,184	19,600	$220,000
MLS Beds	MLS Sq Ft	Lot Sq Ft	MLS Sale Price
3	1949	DUPLEX	11/16/2010
MLS Baths	Yr Built	Type	MLS Sale Date

Owner Information

Owner Name:	**Granillo Jose Leonel Estrada**	Mailing Zip:	**80221**
Owner Name 2:	**Borunda Jose Estrada**	Mailing ZIP 4:	**2210**
Mailing Address:	**2850 W 65th Pl**	Mailing Carrier Route:	**C012**
Mailing City & State:	**Denver, CO**	Owner Occupied:	**No**

Location Information

Property Zip:	**80221**	Census Tract:	**95.02**
Property Zip4:	**2210**	Neighborhood Code:	**Unincorporated Adams-200**
Property Carrier Route:	**C012**	Neighborhood Name (OnBoard):	**Stites Mobile Home Community**
School District:	**Westminster Pub Schl**	Township:	**03S**
Elementary School:	**F. M. Day**	Range:	**68W**
Middle School:	**Scott Carpenter**	Section:	**05**
High School:	**Westminster**	Quarter:	**SE**
Subdivision:	**North Lawn Gardens**	Block:	**2**
Zoning:	**R-2**	Lot:	**6**

Tax Information

PIN:	**R0100716**	% Improved:	**82%**
Alternate PIN:	**1825-05-4-05-006**	Tax District:	**495**
Schedule Number:	**R0100716**		
Legal Description:	**SUB:NORTH LAWN GARDENS BLK:2 LOT:6**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$105,000	$90,000	$90,000
Market Value - Improved	$494,107	$209,292	$209,292
Market Value - Total	$599,107	$299,292	$299,292
Assessed Value - Land	$7,510	$6,480	$6,480
Assessed Value - Improved	$35,330	$15,070	$15,070
Assessed Value - Total	$42,840	$21,550	$21,550
YOY Assessed Change (%)	98.79%	0%	
YOY Assessed Change ($)	$21,290	$0	

Tax Year	Total Tax	Change ($)	Change (%)
2017	$2,340		
2018	$2,669	$329	14.06%
2019	$5,244	$2,576	96.53%

Characteristics

Lot Frontage:	**98**	Bedrooms:	**5**
Lot Depth:	**200**	Baths - Total:	**3**
Lot Acres:	**0.45**	MLS Total Baths:	**3**
Lot Sq Ft:	**19,600**	Baths - Full:	**3**
Land Use - County:	**Duplex/Triplex**	Stories:	**1**

Property Detail

Land Use - CoreLogic:	**Duplex**	Cooling Type:	**Central**
Building Type:	**Duplex**	Heat Type:	**Forced Air**
Style:	**Duplex**	Garage Type:	**Attached Garage**
Year Built:	**1949**	Garage Sq Ft:	**504**
Bldg Sq Ft - Above Ground:	**2,184**	Roof Material:	**Composition Shingle**
Bldg Sq Ft - Total:	**2,184**	Construction:	**Frame**
Bldg Sq Ft - Finished:	**2,184**	Exterior:	**Frame**
Bldg Sq Ft - 1st Floor:	**2,184**	Quality:	**Good**
# Buildings:	**1**	Equipment:	**Whe, Ssk**
Total Rooms:	**10**		

Features

Feature Type	Size/Qty
Water Heater	2
Attached	504
Bath 4	3
Sink Standard	2
Wood Roof	80
Allowance	2
Laundry Facility	2

Building Description	Building Size
Single Family	1

Estimated Value

Value As Of: **05/28/2020**

Listing Information

MLS Listing Id:	**940487**	MLS Listing Contract Date:	**10/18/2010**
MLS Days On Market:	**18**	MLS Close Date:	**11/16/2010**
MLS Status:	**Closed**	MLS List Office Name:	**RE/MAX PROFESSIONALS**
MLS Status Change Date:	**11/16/2010**	MLS List Agent Full Name:	**27101g-Glen Cary**
MLS Current Price:	**$229,900**	MLS Buyer Agent Full Name:	**Nmlsa-Non Mls Agent**
MLS Original List Price:	**$235,000**	MLS Buyer Office Name:	**NON MLS PARTICIPANT**
MLS Close Price:	**$220,000**		

MLS Listing #	934935	875980	867080
MLS Status	Withdrawn	Withdrawn	Withdrawn
MLS Listing Price	$229,900	$105,000	$105,000
MLS Orig Listing Price	$235,000	$105,000	$105,000
MLS Listing Close Price	$0	$0	$0
MLS Listing Date	09/30/2010	04/19/2010	03/29/2010

Last Market Sale & Sales History

Sale Date:	**Tax: 10/20/2010 MLS: 11/16/2010**	Deed Type:	**Warranty Deed**
Sale Price:	**$220,000**	Owner Name:	**Granillo Jose Leonel Estrada**
Price per SqFt - Finished:	**$100.73**	Owner Name 2:	**Borunda Jose Estrada**
Document Number:	**80252**	Seller:	**Denver Arizona LLC**

Sale Date	10/20/2010	12/22/2009	01/30/2003	04/14/1995	09/10/1993
Sale Price	$220,000	$136,000	$101,484	$85,100	$64,000
Buyer	Granillo Jose L E	Denver Arizona LLC	Jones Samuel L	Agado Arnoldo & Theresa	Mora Mike & Dolores
Buyer	Borunda Jose E			Agado Theresa	Mora Dolores
Seller	Denver Arizona LLC	Jones Samuel L	Agado Arnoldo & Theresa	Mora Mike & Dolores	Nagy Paul A
Document Number	80252	96806	C1091184	4507-901	4150-943
Document Type	Warranty Deed	Warranty Deed	Warranty Deed	Warranty Deed	Warranty Deed
Title Company	Other	Land Title Guarantee	Security Title Co		

Mortgage History

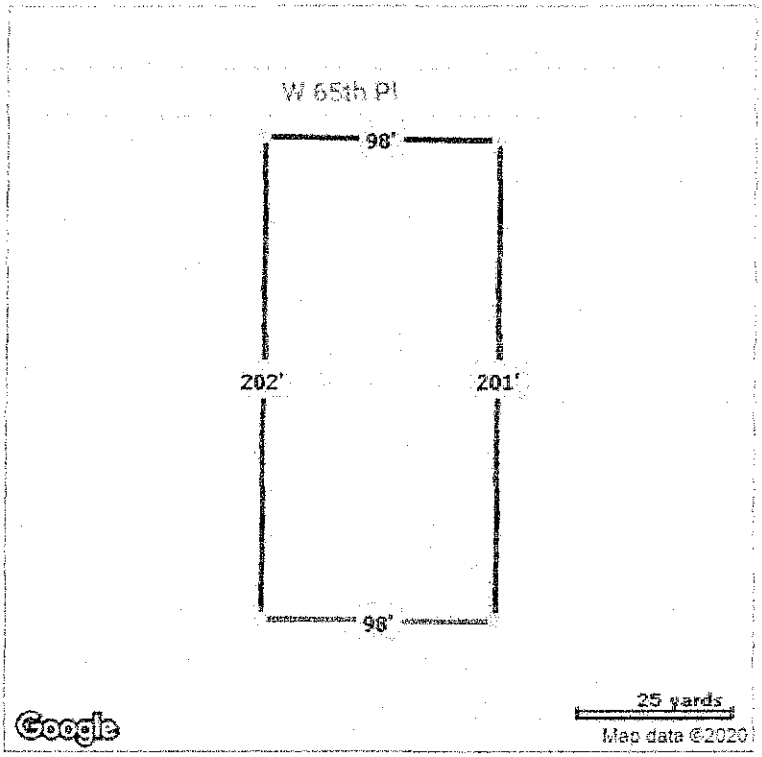
Mortgage Date	06/10/2019	11/18/2010	12/31/2009	02/02/2006	02/02/2006
Mortgage Amount	$350,000	$217,076	$94,500	$37,500	$267,600
Mortgage Lender	Dsw Mtg Inc	Guild Mtg Co	Solera Nat'l Bk	Greenpoint Mtg Fndg	Greenpoint Mtg Fndg
Borrower	Borunda Jose E	Granillo Jose L E	Denver Arizona LLC	Jones Samuel L	Jones Samuel L
Borrower	Granillo Jose L E	Borunda Jose E			
Mortgage Type	Conventional	Fha	Conventional	Conventional	Conventional
Mortgage Purpose	Refi	Resale	Resale	Refi	Refi
Mortgage Int Rate					7.375
Mortgage Int Rate Type			Adjustable Int Rate Loan	Fixed Rate Loan	Adjustable Int Rate Loan
Mortgage Term	30	30		15	30
Mortgage Term	Years	Years		Years	Years
Title Company				Attorneys Title Guaranty Fund	Attorneys Title Guaranty Fund

Mortgage Date	11/17/2005	11/22/2004	03/15/2004
Mortgage Amount	$1,063	$239,000	$39,000
Mortgage Lender	Colonial Bk	Colonial Bk	Colonial Bk
Borrower	Jones Samuel L	Jones Samuel L	Jones Samuel L
Borrower			
Mortgage Type			Conventional
Mortgage Purpose	Construction	Construction	Refi
Mortgage Int Rate			
Mortgage Int Rate Type	Fixed Rate Loan	Fixed Rate Loan	Fixed Rate Loan
Mortgage Term	1	1	
Mortgage Term	Years	Years	
Title Company			

Foreclosure History

Document Type	Release Of Lis Pendens/Notice	Notice Of Trustee's Sale
Foreclosure Filing Date		10/27/2009
Recording Date	03/10/2010	11/12/2009
Document Number	15794	84112
Final Judgment Amount		$267,600
Original Doc Date	11/12/2009	02/02/2006
Original Document Number	84112	116670

Property Map



*Lot Dimensions are Estimated

7515 Stuart St, Westminster, CO 80030-4744, Adams County

Owner Information

Owner Name:	**Glasoe Nicholas & Merwin**	Mailing Zip:	**80030**
Owner Name 2:	**Glasoe Janet**	Mailing ZIP 4:	**4744**
Mailing Address:	**7515 Stuart St**	Mailing Carrier Route:	**C028**
Mailing City & State:	**Westminster, CO**	Owner Occupied:	**Yes**

Location Information

Property Zip:	**80030**	Neighborhood Code:	**Southwest Adams County-64**
Property Zip4:	**4744**	Neighborhood Name (OnBoard):	**Maple Place**
Property Carrier Route:	**C028**	Township:	**02S**
School District:	**Westminster Pub Schl**	Range:	**68W**
Elementary School:	**Harris Park**	Section:	**31**
Middle School:	**Shaw Heights**	Quarter:	**NE**
High School:	**Westminster**	Block:	**2**
Subdivision:	**Maple Place**	Lot:	**7**
Census Tract:	**96.04**		

Tax Information

PIN:	**R0064627**	% Improved:	**92%**
Alternate PIN:	**1719-31-3-10-007**	Tax District:	**555**
Schedule Number:	**R0064627**		
Legal Description:	**SUB:MAPLE PLACE BLK:2 LOT:7 DESC: AND N 10 FT OF LOT 8**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$48,450	$48,450	$48,450
Market Value - Improved	$581,563	$378,510	$378,510
Market Value - Total	$630,013	$426,960	$426,960
Assessed Value - Land	$3,460	$3,490	$3,490
Assessed Value - Improved	$41,580	$27,250	$27,250
Assessed Value - Total	$45,040	$30,740	$30,740
YOY Assessed Change (%)	46.52%	0%	
YOY Assessed Change ($)	$14,300	$0	

Tax Year	Total Tax	Change ($)	Change (%)
2017	$2,706		
2018	$3,218	$512	18.94%
2019	$4,624	$1,405	43.67%

Characteristics

Lot Acres:	**0.2225**	Baths - Total:	**4**
Lot Sq Ft:	**9,690**	MLS Total Baths:	**4**
Land Use - County:	**Multi-Unit 4-8 Unit**	Baths - Full:	**4**
Land Use - CoreLogic:	**Multi Family 10 Units Less**	Stories:	**1**
Building Type:	**Multi Family**	Heat Type:	**Baseboard**
Year Built:	**1964**	Roof Material:	**Composition Shingle**
Bldg Sq Ft - Above Ground:	**2,944**	Construction:	**Frame**
Bldg Sq Ft - Total:	**2,944**	Exterior:	**Frame/Masonry**
Bldg Sq Ft - Finished:	**2,944**	Foundation:	**Concrete**
# Buildings:	**1**	Quality:	**Average**
Total Rooms:	**16**	Equipment:	**Whe**
Bedrooms:	**8**		

Features

Feature Type	Size/Qty
Acctsf	2,944
Avgunitsz	736
Bath 4	4
Water Heater	1
Allowance	4
Garden Level	1,472

Building Description	Building Size
Apt 4-8 Units	1

Estimated Value

Value As Of: **05/02/2020**

Listing Information

MLS Listing Id:	**1128397**	MLS Listing Contract Date:	**09/12/2012**
MLS Days On Market:	**21**	MLS Close Date:	**12/05/2012**
MLS Status:	**Closed**	MLS List Office Name:	**PUBLIC REALTY COMPANY**
MLS Status Change Date:	**12/07/2012**	MLS List Agent Full Name:	**241355-Patrick Harris**
MLS Current Price:	**$219,900**	MLS Buyer Agent Full Name:	**032414-Matthew Schulze**
MLS Original List Price:	**$219,900**	MLS Buyer Office Name:	**KELLER WILLIAMS AVENUES REALTY**
MLS Close Price:	**$225,000**		

Last Market Sale & Sales History

Sale Date:	**Tax: 10/12/2012 MLS: 12/05/2012**	Deed Type:	**Special Warranty Deed**
Sale Price:	**$225,000**	Owner Name:	**Glasoe Nicholas & Merwin**
Price per SqFt - Finished:	**$76.43**	Owner Name 2:	**Glasoe Janet**
Document Number:	**92643**	Seller:	**Federal Hm Ln Mtg Corp**

Sale Date	10/12/2012	07/02/2012	07/06/2012	06/15/2007	04/19/2007
Sale Price	$225,000			$345,000	$124,861
Nominal		Y	Y		
Buyer	Glasoe Nicholas & Merwin	Federal Hm Ln Mtg Corp	Bank Of America	Gray Troy & Stephanie	Finam LLC
Buyer	Glasoe Janet			Gray Stephanie	
Seller	Federal Hm Ln Mtg Corp	Bank Of America	Public Trustee Of Adams County	Korpal Investment Props LLC	Public Trustee Of Adams County
Document Number	92643	49405	48322	59744	39792
Document Type	Special Warranty Deed	Special Warranty Deed	Public Trustees Deed	Warranty Deed	Certificate Of Redemption
Title Company	Assured Title Agency	Other		Stewart Title	

Sale Date	04/19/2007	04/16/2007	02/07/2007
Sale Price	$210,000	$205,000	$123,300
Nominal			
Buyer	Korpal Investment Props LLC	Jdin LLC	US Bank Na Trust 2006-Bc1
Buyer			
Seller	Decker Cheri	Dee Cheri	Public Trustee Of Adams County
Document Number	38998	38794	17776
Document Type	Warranty Deed	Contract Of Sale	Public Trustees Deed
Title Company			

Mortgage History

Mortgage Date	12/07/2012	10/03/2007	06/20/2007	01/13/2006	05/28/2003
Mortgage Amount	$171,703	$281,250	$276,000	$355,500	$317,025
Mortgage Lender	Cu Members Mtg	Quicken Lns	First Magnus Fin'l Corp	Finam LLC	United Cap Mtg
Borrower	Glasoe Nicholas & Merwin	Gray Troy	Gray Troy	Decker Cheri	Jensen Bryan
Borrower	Glasoe Janet	Gray Stephanie	Gray Stephanie		
Mortgage Type	Fha	Conventional	Conventional	Conventional	Fha
Mortgage Purpose	Resale	Refi	Resale	Resale	Resale
Mortgage Int Rate			9.5	6.15	4.25
Mortgage Int Rate Type			Adjustable Int Rate Loan	Adjustable Int Rate Loan	Adjustable Int Rate Loan
Mortgage Term	30	30	30	30	30
Mortgage Term	Years	Years	Years	Years	Years
Title Company		Title Sources Inc			

Mortgage Date	03/04/1999	10/29/1997	05/15/1989
Mortgage Amount	$153,300	$181,340	$115,000
Mortgage Lender	Capitol Commerce Mtg	Westamerica Mtg Co	Sunbelt Nat'l Mtg
Borrower	Martin L T	Nguyen Mai A T	Marotta Michael D
Borrower	Martin Judith C		
Mortgage Type	Conventional	Fha	Fha
Mortgage Purpose	Resale	Resale	Resale
Mortgage Int Rate			
Mortgage Int Rate Type			

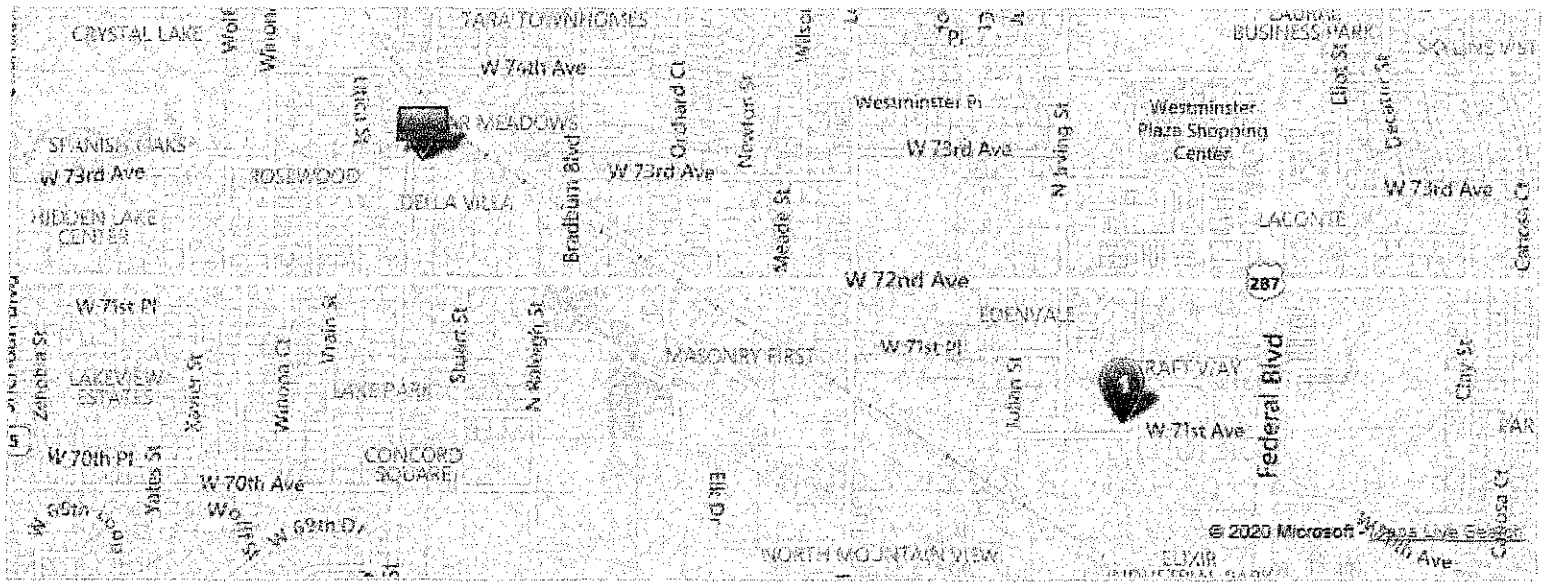
Mortgage Term			
Mortgage Term			
Title Company			

Foreclosure History

Document Type	Certificate Of Purchase	Notice Of Trustee's Sale	Notice Of Trustee's Sale
Default Date		07/20/2011	
Foreclosure Filing Date		07/20/2011	11/29/2006
Recording Date	06/22/2012	07/25/2011	12/12/2006
Document Number	45068	46789	1009773
Final Judgment Amount	$107,117	$270,564	$353,410
Original Doc Date	10/03/2007	10/03/2007	01/13/2006
Original Document Number	93662	93662	52020

Property Detail

7326 Tennyson St, Westminster 80030-5171, Adams County

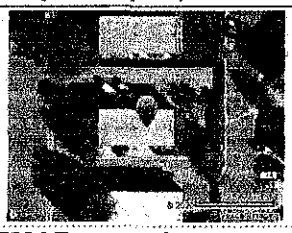


Search Criteria

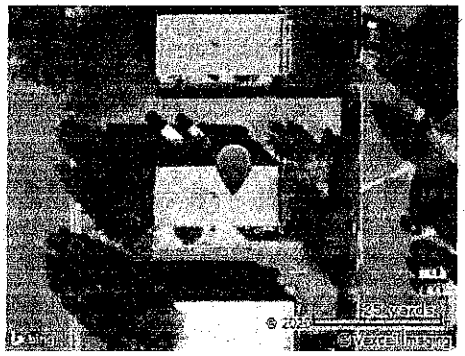
Number of Comparables:	**1**	Search Period:	**08/18/2019 - 05/18/2020**
Sort Method:	**Distance From Subject (Closest)**	Living/Building Area:	**3,264 - 4,416 Sq Ft**
Pool:	**No Preference**	Lot Area:	**8,288 - 11,212 Sq Ft**
Distance from Subject:	**2 miles**	Land Use:	**Same As Subject**
Site Influence:	**No Preference**		

Summary Statistics

	Subject Property	High	Low	Median	Average
Sale Price	$310,000	$657,700	$657,700	$657,700	$657,700
Price per SqFt - Finished	$80.73	$193.21	$193.21	$193.21	$193.21
Bldg Sq Ft - Finished	3,840	3,404	3,404	3,404	3,404
Lot Sq Ft	9,750	10,890	10,890	10,890	10,890
Bedrooms	8	4	4	4	4
Baths - Total	8	4	4	4	4
Stories	2	1	1	1	1
Year Built	1973	1973	1973	1973	1973
Distance (miles)		0.89	0.89	0.89	0.89
Total Assessment	$722,471	$551,741	$551,741	$551,741	$551,741
Value Projected by Assessment	$861,218				
Value Projected by Sq Ft	$741,926				

	Subject Property	Comparable 1
		
Address	7326 Tennyson St	7101 Hooker St
Property City	Westminster	Westminster
Property Zip	80030	80030
School District	Westminster Pub Schl	Westminster Pub Schl
Distance (miles)		0.89
PIN	R0064833	R0100083
Land Use - County	Multi-Unit 4-8 Unit	Multi-Unit 4-8 Unit
Land Use - CoreLogic	Multi Family 10 Units Less	Multi Family 10 Units Less
Annual Tax	$5,303	$4,174
Sale Date	*10/06/2000*	Tax: 11/21/2019 MLS: 11/22/2019
Sale Price	$310,000	$657,700
Year Built	1973	1973
Bldg Sq Ft - Finished	3,840	3,404
Stories	2	1
Bedrooms	8	4
Baths - Total	8	4
Baths - Full	*8*	4
Fireplaces		4
Exterior	Frame/Masonry	Frame/Masonry
Roof Material	*Wood Shake*	*Built-Up*
Heat Type	Baseboard	Baseboard
Cooling Type		Wall
Lot Acres	0.2238	0.25
Lot Sq Ft	9,750	10,890
Price per SqFt - Finished	$80.73	$193.21
Township-Range-Section	2S-68W-31	3S-68W-5
Subdivision	Quimbys Add To Westminster Second Filing	*Shannon Indust Park*
MLS Listing Id	1123157	2754313

7326 Tennyson St, Westminster, CO 80030-5171, Adams County



8	3,840	9,750	$310,000
Beds	MLS Sq Ft	Lot Sq Ft	Sale Price
8	1973	MLT FAM <10	10/06/2000
Baths	Yr Built	Type	Sale Date

Expired Listing

Owner Information

Owner Name:	**Ngo Dieu**	Mailing Zip:	**80260**
Owner Name 2:	**Tran Binh Ai**	Mailing ZIP 4:	**4839**
Mailing Address:	**642 Milky Way**	Mailing Carrier Route:	**C025**
Mailing City & State:	**Thornton, CO**	Owner Occupied:	**No**

Location Information

Property Zip:	**80030**	Census Tract:	**96.04**
Property Zip4:	**5171**	Neighborhood Code:	**Southwest Adams County-64**
Property Carrier Route:	**C024**	Neighborhood Name (OnBoard):	**Quimbys**
School District:	**Westminster Pub Schl**	Township:	**02S**
Elementary School:	**Harris Park**	Range:	**68W**
Middle School:	**Shaw Heights**	Section:	**31**
High School:	**Westminster**	Quarter:	**NE**
Subdivision:	**Quimbys Add To Westminster Second Filing**	Lot:	**5**

Tax Information

PIN:	**R0064833**	% Improved:	**93%**
Alternate PIN:	**1719-31-3-23-005**	Tax District:	**555**
Schedule Number:	**R0064833**		
Legal Description:	**DESC: LOT 5 QUIMBY'S ADD TO WESTMINSTER SECOND FILING**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$48,750	$48,750	$48,750
Market Value - Improved	$673,721	$442,857	$442,857
Market Value - Total	$722,471	$491,607	$491,607
Assessed Value - Land	$3,490	$3,510	$3,510
Assessed Value - Improved	$48,170	$31,890	$31,890
Assessed Value - Total	$51,660	$35,400	$35,400
YOY Assessed Change (%)	45.93%	0%	
YOY Assessed Change ($)	$16,260	$0	

Tax Year	**Total Tax**	**Change ($)**	**Change (%)**
2017	$3,116		
2018	$3,655	$539	17.31%
2019	$5,303	$1,648	45.07%

Characteristics

Lot Acres:	**0.2238**	Bedrooms:	**8**
Lot Sq Ft:	**9,750**	Baths - Total:	**8**
Land Use - County:	**Multi-Unit 4-8 Unit**	Baths - Full:	**8**
Land Use - CoreLogic:	**Multi Family 10 Units Less**	Stories:	**2**
Building Type:	**Multi Family**	Heat Type:	**Baseboard**
Year Built:	**1973**	Roof Material:	**Wood Shake**

Property Detail

Bldg Sq Ft - Above Ground:	**3,840**	Construction:	**Frame**
Bldg Sq Ft - Total:	**3,840**	Exterior:	**Frame/Masonry**
Bldg Sq Ft - Finished:	**3,840**	Foundation:	**Concrete**
# Buildings:	**1**	Quality:	**Good**
Total Rooms:	**20**	Equipment:	**Whe**

Features

Feature Type	Size/Qty
Acctsf	3,840
Yd. Imps.-Asphalt Average	2,144
Avgunitsz	960
Water Heater	4
Bath 4	4
Bath 2	4
Allowance	4

Building Description	Building Size
Apt 4-8 Units	1

Estimated Value

Value As Of: **05/02/2020**

Listing Information

MLS Listing Id:	**1123157**	MLS Original List Price:	**$345,000**
MLS Days On Market:	**240**	MLS Listing Contract Date:	**08/23/2012**
MLS Status:	**Expired**	MLS List Office Name:	**PINNACLE REAL ESTATE ADVISORS**
MLS Status Change Date:	**02/15/2013**	MLS List Agent Full Name:	**01439n-Josh Newell**
MLS Current Price:	**$345,000**		

MLS Listing #	1115067
MLS Status	Expired
MLS Listing Price	$690,000
MLS Orig Listing Price	$690,000
MLS Listing Date	07/26/2012
MLS Listing Expiration Date	06/11/2013

Last Market Sale & Sales History

Sale Date:	**10/06/2000**	Deed Type:	**Warranty Deed**
Sale Price:	**$310,000**	Owner Name:	**Ngo Dieu**
Price per SqFt - Finished:	**$80.73**	Owner Name 2:	**Tran Binh Ai**
Document Number:	**6289-843**	Seller:	**Trinh Phuc V**
Sale Type:	***Full***		

Sale Date	10/06/2000	01/11/1999	11/21/1996	03/20/1992	07/16/1991
Sale Price	$310,000	$240,000	$187,500	$111,000	
Nominal					Y
Buyer	Ngo Dieu	Trinh Phuc V	Gilmore Richard J & Virginia	Lombardi Fred & Lombardi K M	Weaver Gary D & Weaver Betty A
Buyer			Gilmore Virginia	Lombardi Lombardi K M	Weaver Weaver Betty A
Seller	Trinh Phuc V	Gilmore Richard J & Virginia	Lombardi Fred & Kathy M	Weaver Gary D & Weaver Betty A	Weaver Gary D & Weaver Betty A
Document Number	6289-843	5619-968	4893-786	3882-20	3801-920
Document Type	Warranty Deed	Warranty Deed	Warranty Deed	Warranty Deed	Deed (Reg)
Title Company		First American Title Insurance			

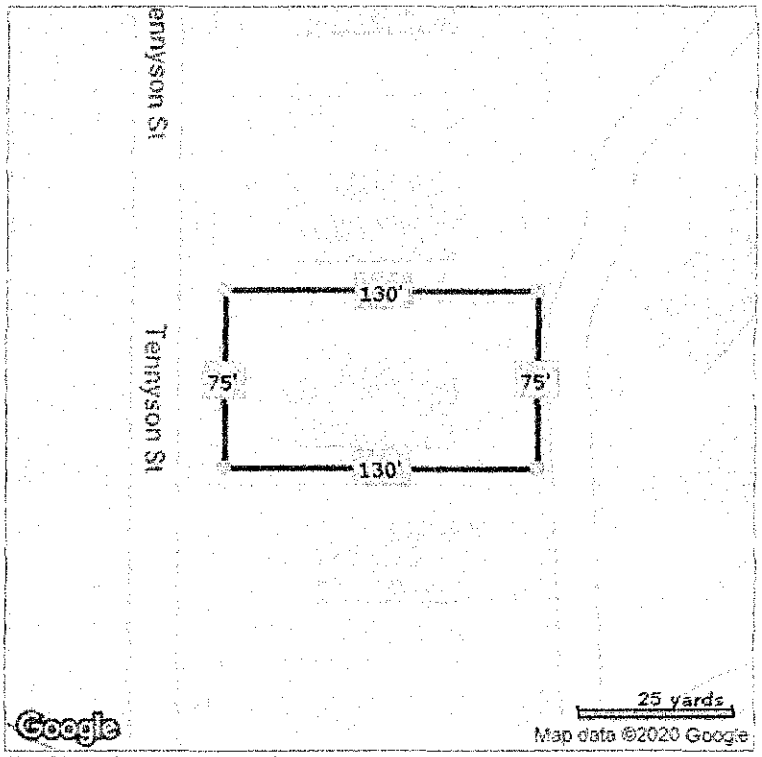
Sale Date	12/31/1986
Sale Price	
Nominal	
Buyer	Weaver Gary D
Buyer	

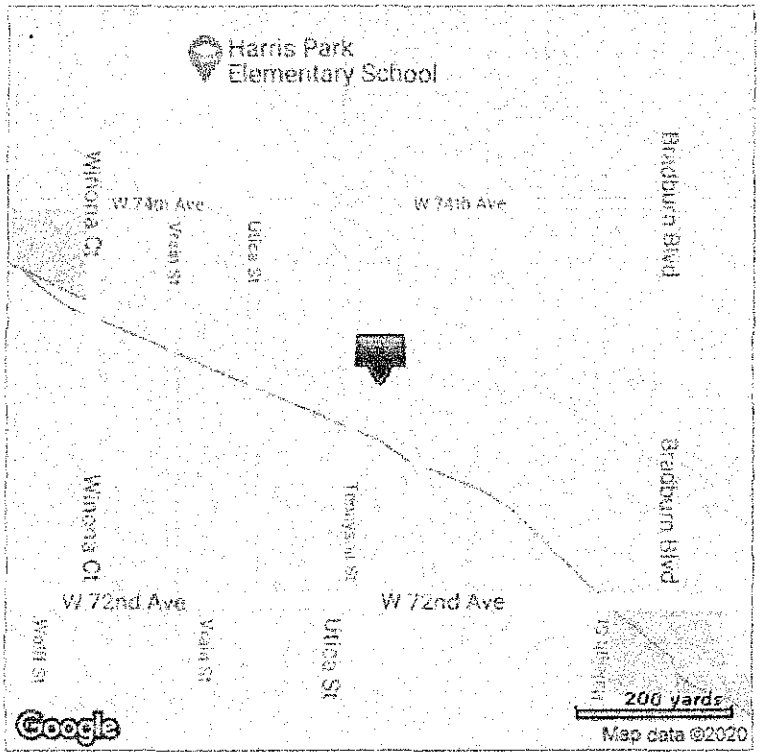
Seller	Titus Myer L
Document Number	3253-870
Document Type	Warranty Deed
Title Company	

Mortgage History

Mortgage Date	02/11/2002	10/16/2000	01/20/1999	12/05/1996
Mortgage Amount	$231,000	$248,000	$238,038	$140,625
Mortgage Lender	Rbmg Inc	Washington Mutual Bk Fa	Temple Inland Mtg Corp	World S&L
Borrower	*Ngo Dieu*	*Ngo Dieu*	*Trinn Phuc V*	*Gilmore Richard J*
Borrower				Gilmore Virginia
Mortgage Type	Conventional	Conventional	Fha	Conventional
Mortgage Purpose	*Refi*	*Resale*	*Resale*	*Resale*
Mortgage Int Rate Type	Fixed Rate Loan	Adjustable Int Rate Loan		Adjustable Int Rate Loan
Mortgage Term	15	15		
Mortgage Term	Years	Years		
Title Company	First American Heritage Title			

Property Map





*Lot Dimensions are Estimated

Property Detail

Generated on 05/18/2020

5320 King Ct, Denver, CO 80221-6561, Adams County

4	1,912	8,632	$249,900
Beds	Bldg Sq Ft	Lot Sq Ft	Sale Price
2	1972	DUPLEX	03/31/2003
Baths	Yr Built	Type	Sale Date

Owner Information

Owner Name:	**Fox Barbara J**	Mailing ZIP 4:	**6561**
Mailing Address:	**5320 King Ct**	Mailing Carrier Route:	**C002**
Mailing City & State:	**Denver, CO**	Owner Occupied:	**Yes**
Mailing Zip:	**80221**		

Location Information

Property Zip:	**80221**	Census Tract:	**97.51**
Property Zip4:	**6561**	Neighborhood Code:	**Unincorporated Adams-200**
Property Carrier Route:	**C002**	Neighborhood Name (OnBoard):	**Regis**
School District:	**Westminster Pub Schl**	Township:	**03S**
Elementary School:	**Hodgkins**	Range:	**68W**
Middle School:	**Scott Carpenter**	Section:	**17**
High School:	**Westminster**	Quarter:	**NW**
Subdivision:	**Befus Sub 2nd Fil**	Block:	**2**
Zoning:	**R-2**	Lot:	**4**

Tax Information

PIN:	**R0105067**	% Improved:	**61%**
Alternate PIN:	**1825-17-2-12-020**	Tax District:	**480**
Schedule Number:	**R0105067**		
Legal Description:	**SUB:BEFUS SUBD 2ND FIL BLK:2 LOT:4**		

Assessment & Tax

Assessment Year	2019	2018	2017
Market Value - Land	$177,000	$135,000	$135,000
Market Value - Improved	$280,512	$75,500	$75,500
Market Value - Total	$457,512	$210,500	$210,500
Assessed Value - Land	$12,660	$9,720	$9,720
Assessed Value - Improved	$20,060	$5,440	$5,440
Assessed Value - Total	$32,720	$15,160	$15,160
YOY Assessed Change (%)	115.83%	0%	
YOY Assessed Change ($)	$17,560	$0	

Tax Year	Total Tax	Change ($)	Change (%)
2017	$1,195		
2018	$1,365	$170	14.2%
2019	$3,516	$2,152	157.63%

Characteristics

Lot Acres:	**0.1982**	Bedrooms:	**4**
Lot Sq Ft:	**8,632**	Baths - Total:	**2**
Lot Shape:	**Dxt**	Baths - Full:	**2**
Land Use - County:	**Duplex/Triplex**	Stories:	**1**
Land Use - CoreLogic:	**Duplex**	Cooling Type:	**Central**
Building Type:	**Duplex**	Heat Type:	**Forced Air**

Property Detail

Generated on: 05/18/2020

Style:	**Duplex**	Garage Type:	**Attached Garage**
Year Built:	**1972**	Garage Sq Ft:	**462**
Bldg Sq Ft - Above Ground:	**1,912**	Roof Material:	**Composition Shingle**
Bldg Sq Ft - Total:	**1,912**	Construction:	**Frame**
Bldg Sq Ft - Finished:	**1,912**	Exterior:	**Frame/Masonry**
Bldg Sq Ft - 1st Floor:	**1,912**	Quality:	**Average**
# Buildings:	**1**	Equipment:	**Ssk, Whe**
Total Rooms:	**10**		

Features

Feature Type	Size/Qty
Open Slab	460
Attached	462
Sink Standard	2
Rough In	2
Allowance	1
Bath 4	2
Laundry Facility	2
Water Heater	2

Building Description	Building Size
Duplex	1

Estimated Value

Value As Of: **05/02/2020**

Last Market Sale & Sales History

Sale Date:	**03/31/2003**	Deed Type:	**Warranty Deed**
Sale Price:	**$249,900**	Owner Name:	**Fox Barbara J**
Price per SqFt - Finished:	**$130.70**	Seller:	**Waitman Eileen**
Document Number:	**C1119434**		

Sale Date	03/31/2003	09/08/1998	12/14/1988	
Sale Price	$249,900	$159,900		$120,000
Nominal			Y	
Buyer	Fox Barbara J	Waitman Eileen	Lyness Patrick A	Crum Patricia
Seller	Waitman Eileen	Lyness Patrick A	Lyness Patrick	Goul Patricia C
Document Number	C1119434	5463-674	3524-24	2946-292
Document Type	Warranty Deed	Warranty Deed	Warranty Deed	Warranty Deed
Title Company	Land Title Corp			
Multi/Split Sale Type	Multiple			

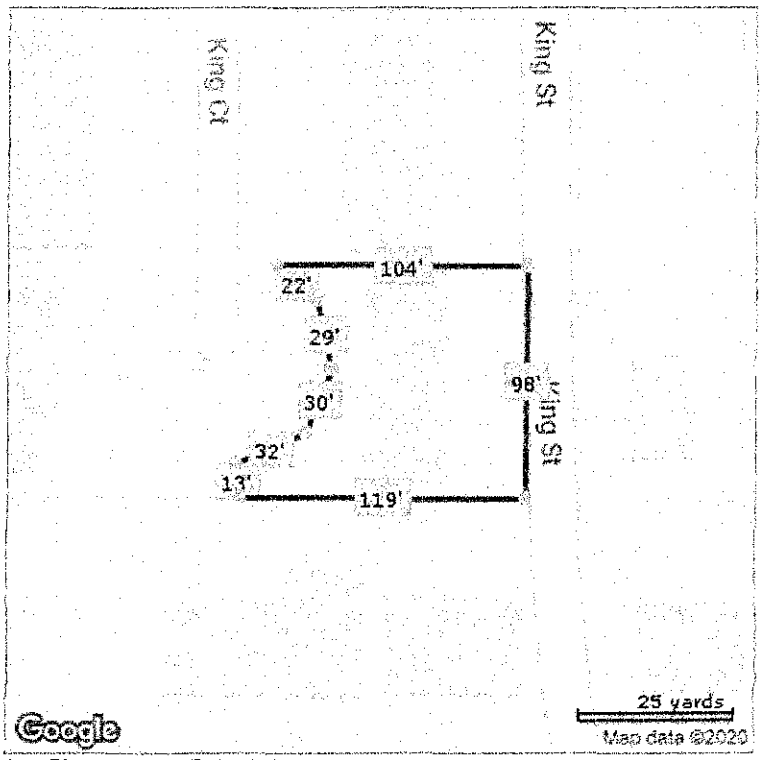
Mortgage History

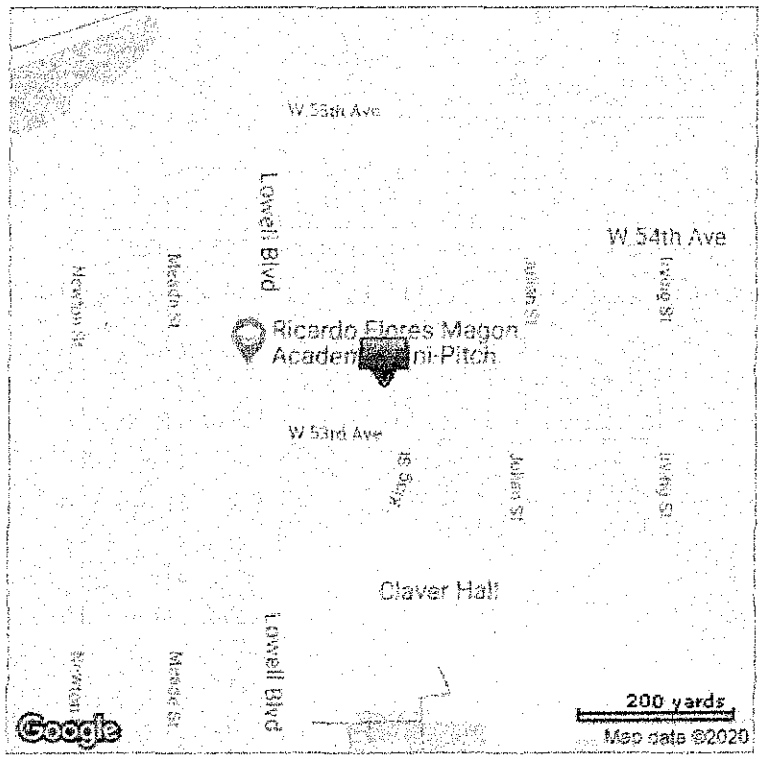
Mortgage Date	03/13/2017	09/17/2009	12/15/2004	04/02/2003	09/11/1998
Mortgage Amount	$168,000	$189,750	$50,000	$199,900	$127,900
Mortgage Lender	Guaranty Tr Co	Bank Of America	Citibank Fsb	Union Planters Bk	Colorado Bankers Mtg
Borrower	Fox Barbara J	Fox Barbara J	Fox Barbara J	Fox Barbara J	Waitman Eileen
Mortgage Type	Conventional	Conventional	Conventional	Conventional	Conventional
Mortgage Purpose	Refi	Refi	Refi	Resale	Resale
Mortgage Int Rate Type			Fixed Rate Loan	Fixed Rate Loan	
Mortgage Term	30	30	30	30	
Mortgage Term	Years	Years	Years	Years	
Title Company	Fidelity National Title Insura	Stewart Title	Nationwide Appraisal & Title		

Mortgage Date	12/12/1984
Mortgage Amount	$44,400
Mortgage Lender	
Borrower	Crum Patricia
Mortgage Type	Private Party Lender

Mortgage Purpose	Resale
Mortgage Int Rate Type	
Mortgage Term	
Mortgage Term	
Title Company	

Property Map





*Lot Dimensions are Estimated

3421 W Arkansas Avenue, Denver, CO 80219 — $362,500 - Closed

Listing

Listing ID:	**6157008**	MLS Status:	**Closed**
List Price:	**$450,000**	Original List Price:	**$450,000**
Property Type:	**Residential Income/Triplex**		
Levels:	**One**	Basement:	**No**
County:	**Denver**	Year Built:	**2000**
Subdivision Name:	**Garfield Heights**		
Listing Contract Date:	**02/14/2020**	Spec. Listing Cond:	**None Known**
Purchase Contract Date:	**02/23/2020**	Contingency:	**None Known**
Close Date:	**03/05/2020**	Close Price:	**$362,500**
Days in MLS:	**10**		
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Anni:	**$0**
Tax Annual Amt:	**$1,328**	Tax Year:	**2018**
Tax Legal Desc:	**GARFIELD HEIGHTS ANNEX W 51.25 FT OF E 122.50FT OF PLOT 83**		

Interior Area & SqFt

Building Area Total (SqFt Total):	**1,540**	Living Area (SqFt Finished):	**1,540**	Area Source:	
Above Grade Finished Area:	**1,540**				
Below Grade Total Area:	**0**	Below Grade Finished Area:	**0**	Below Grade Unfinished Area:	**0**
PSF Total:	**$235**	PSF Above Grade:	**$235**	PSF Finished:	**$235**

Heating: **Forced Air, Natural Gas** # FP, FP Features **0**
Cooling: **None**
Interior Features: **Ceiling Fan(s), Kitchen Island, Laminate Counters, Master Suite, No Stairs, Open Floorplan**
Security Features: Flooring: **Laminate**
Appliances: **Cooktop, Dishwasher, Dryer, Gas Water Heater, Oven, Range Hood, Refrigerator, Washer**
Other Equipment: Laundry: **In Unit, Main Level**
Exclusions: **All personal property owned by tenants.**

Financials & Expenses

Cap Rate:	**6.60**	Cap Rate Calculation:	
Actual		Projected	
Gross Income:	**35,910.00**	Gross Income:	**35,910.00**
Operating Expense:	**5,880.00**	Annual Expense:	**5,880.00**
Annual Net Income:	**30,030.00**	Annual Net Income:	**30,030.00**

Operating Expense Includes: **Insurance, Personal Property Tax, Professional Management**
Owner Pays: **Insurance** Utility Billing To Tenants: **Included in Rent**
Tenant Pays: **Cable TV, Electricity, Gas, Internet, None, Water** Utility Metering: **Common Electric, Common Gas, Common Water**

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
2 Bedroom	**1**	**$1,325**		**1**	**2**	**2**	**1**	**1**	**1**		**2**	**1**	**1**			
Studio	**1**	**$850**		**1**		**1**					**1**	**1**				
Studio	**1**	**$775**		**1**		**1**					**1**	**1**				

Parking

Parking Total: **7** Garage Spaces: **0** Offstreet Spaces: **7**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	**7**			

Site & Location Information

Lot Size: **0.15 Acres / 6,376 SqFt**
Lot Features: **Level, Near Public Transit**
Road Responsibility: **Public Maintained Road**
Bldg/Complex Name:
Parcel Number: **5202-08-052**
Is Incorporated:
Walk Score: **65**

Fencing: **None**
Elementary School: **Cms Community / Denver 1**
Middle/Junior Sch: **Grant / Denver 1**
High School: **Abraham Lincoln / Denver 1**
School of Choice:
Zoning: **S-SU-D**
View Walk, Bike, & Transit Scores

Building Information

Architectural Style: **Traditional**
Entry Level/Loc: **Exterior Access** Common Walls:
Construction Materials: **Frame, Vinyl Siding**
Roof: **Composition** Exterior Features:
Patio/Porch Feat: **Covered** Pool Features:

Water & Utilities

Water Source:	**Public**	Sewer:	**Public Sewer**
Utilities:	**Cable Available, Electricity Connected, Phone Available**	Electric:	

Public Remarks

BEAUTIFUL INVESTMENT OPPORTUNITY!!! This triplex features two studio units and one 2 bed-2 bath unit. Current gross monthly rental income is $2950 ($775, $1325, $850). There are new floors in units 2 and 3 as well as new cabinets in unit 3. Each unit has countless new updates. The water heater for all units has just been replaced. All bedrooms are non-conforming. Materials for a new roof have been purchased. The owner and contractor are waiting for the weather to improve to do a full remove and replace. This property is in a wonderful, well-sought-out location. Home is a manufactured *home. 15 minutes from downtown with public transportation nearby. Property is sold AS IS.*

Confidential Information

Private Remarks: **Please direct ALL questions & correspondence to Celena Hinkelman at (720) 793-6842, Celena@OneHomeColorado.com All information deemed reliable, buyer/buyer's agent to verify all. Offers to be submitted through CTME to contracts@onehomecolorado.com. Three different units. Please allow at least 24 hours notice in order to schedule showings for all three units. Request showing through ShowingTime and Listing Agent will contact you to confirm showings and provide lockbox info.**

Buyer Agency Comp:	**2.8%**	Dual Variable:	**No**	Submitted Prosp:	**No**
Contract Earnest Check To:	**Land Title**			Possession:	
Contract Min Earnest:	**$4,000**	Listing Terms:	**Cash, Conventional**		
Title Company:	**Land Title**			Ownership:	**Individual**

List Agent

List Agent:	Steve Nickerson	Phone:	**303-885-5675**		
List Agent ID:	**046763**	Mobile:	**303-885-5675**		
		Office:	**303-471-6165**		
List Office:	Keller Williams Executives	Email:	nickersonteam@gmail.com	List Office ID:	**KWR37**
Co List Agent:	Celena Hinkelman	Phone:	**720-793-6842**	Co List Agent ID:	**55050041**
Co List Office:	Keller Williams Executives	Email:	cele.hink@gmail.com	Co List Office ID:	**KWR37**

Buyer Agent

Buyer Agent:	Michael Stelly	Phone:	**337-303-7126**	Buyer Agent ID:	**55050990**
Buyer Office:	New Western Acquisitions	Email:	michael.stelly@newwestern.com	Buyer Office ID:	**M3538**

Close Information

Concessions:	**No**	Buyer Financing:	**Cash**
Commission Modified:	**NA**	Closing Comments:	

Generated on:
06/05/2020 9:23:16 AM

Tax

Characteristics

Lot Acres:	**0.146**	Lot Sq Ft:	**6,376**
Land Use - County:	**Single Family Resident**	Land Use - CoreLogic:	**Sfr**
Year Built:	**2000**	Bldg Sq Ft - Above Ground:	**1,540**
Bldg Sq Ft - Total:	**1,540**	*Bldg Sq Ft - Finished:*	**1,540**
Bldg Sq Ft - 1st Floor:	**1,540**	# Buildings:	**1**
Total Rooms:	**6.000**	Bedrooms:	**3**
Baths - Total:	**2**	Baths - Full:	**2.000**
Stories:	**1.0**	Heat Type:	**Warm Air**
Garage Type:	**Parking Avail**	Garage Capacity:	**0**
Exterior:	**Aluminum/Vinyl**	Quality:	**AVERAGE**

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Opn Prch-Frm	**S**	**140**			

Owner Information

Owner Name:	**Dary Llc**	Mailing Address:	**7303 E Bates Dr**
Mailing City & State:	**Denver Co**	Mailing Zip:	**80231**
Mailing ZIP 4:	**6010**	Mailing Carrier Route:	**C034**

Owner Occupied:	**No**

Location Information

Property Zip:	**80219**	Property Zip4:	**3477**
Property Carrier Route:	**C022**	School District:	**Denver County 1**
Elementary School:	**CMS COMMUNITY SCHOOL**	Middle School:	**COMPASS**
		High School:	**ABRAHAM LINCOLN**
Subdivision:	**Garfield Heights Annex**	Zoning:	**S-SU-D**
Census Tract:	**004602**	Topography:	**FLAT/LEVEL**
Neighborhood Code:	**0581**	Onboard Neighborhood Description:	**MAR LEE**
Traffic:	**Local**	Township Range and Section:	**4S6820**
Quarter:	**NW**	Lot:	**83**

Tax Information

PIN:	**5202-08-052**	Alternate PIN:	**162923270**
Schedule Number:	**0520208052000**	% Improved:	**76**
Tax District:	**DENV**		
Legal Description:	**GARFIELD HEIGHTS ANNEX W 51.25 FT OF E 122.50FT OF PLOT 83**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$76,200**	**$60,400**	**$60,400**
Market Value - Improved	**$245,200**	**$178,000**	**$178,000**
Market Value - Total	**$321,400**	**$238,400**	**$238,400**
Assessed Value - Land	**$5,450**	**$4,350**	**$4,350**
Assessed Value - Improved	**$17,530**	**$12,820**	**$12,820**
Assessed Value - Total	**$22,980**	**$17,170**	**$17,170**
YOY Assessed Change ($)	**$5,810**	**$**	
YOY Assessed Change (%)	**34%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$1,657.22**	**$1,328.36**	**$1,324.39**
Change ($)	**$329**	**$4**	
Change (%)	**25%**	**0%**	

Last Market Sale

Sale Date:	**03/05/2020**	Price per SqFt - Finished:	**$240.26**
Document Number:	**000000047906, 000000237850**	Deed Type:	**Special Warranty Deed**
		Owner Name:	**Dary Llc**
Seller Name:	**United Colorado Llc**		

History

Listing History from MLS

ListingID: 6157008 Sts: Closed
Parcel #: 5202-08-052

3421 W Arkansas Avenue, Denver, CO 80219
Residential Income, Triplex

LA: Steve Nickerson
LO: Keller Williams Executives

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
03/05/2020	Closed	($362,500)	03/06/20 - 01:09 PM	10
02/23/2020	Pending	ACT->PND	02/24/20 - 10:30 AM	10
02/14/2020	New Listing	ACT-> $450,000	02/14/20 - 05:12 PM	

ListingID: 7626217 Sts: Expired
Parcel #: 5202-08-052

3421 W Arkansas Avenue, Denver, CO 80219
Residential, Single Family Residence

LA: Brad Uhlig
LO: Mb Metro Brokers Dtc

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
05/26/2019	Expired	ACT->EXP	05/27/19 - 12:10 AM	186

04/19/2019	Price Decrease	$379,000->$369,000	04/19/19 - 09:38 AM	149
04/04/2019	Price Decrease	$385,000->$379,000	04/04/19 - 08:08 AM	134
03/05/2019	Price Decrease	$399,000->$385,000	03/05/19 - 07:27 PM	104
11/21/2018	New Listing	ACT-> $399,000	11/21/18 - 10:54 AM	

ListingID: 7732430 Sts: Expired **3421 W Arkansas Avenue, Denver, CO 80219** LA: Brad Uhlig
Parcel #: 5202-08-052 **Residential Income, Triplex** LO: Mb Metro Brokers-Dtc

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
02/28/2019	Expired	WTH->EXP	02/27/19 - 12:10 AM	11
11/21/2018	Withdrawn	ACT->WTH	11/21/18 - 10:53 AM	11
11/10/2018	New Listing	ACT-> $399,000	11/10/18 - 11:24 AM	

Sale History from Public Records

Sale Date	Sale Price	Nonm	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
03/05/20	$370,000		Dary Llc	United Colorado Llc	35547	Special Warranty Deed	Tiago Nat'l Title	
03/04/20	$362,500		United Colorado Llc	Bowen Vincent	34882	Warranty Deed	Tiago Nat'l Title	
05/04/06	$119,100		Bowen Vincent	Hud	83165	Special Warranty Deed	Vista Title Inc	
11/24/04		Y	Hud	Public Trustee Of Denver County	243406	Public Trustees Deed		
08/10/04	$186,017		Midfirst Bank	Public Trustee Of Denver County	168282	Public Trustees Deed		
05/18/01	$173,900		Trejo Rodolfo	Premium Ventures Of Colorado Llc	85196	Warranty Deed	Stewart Title	

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate Type	Borrower Name(s):	Title Company
03/11/20	$277,500			YEARS	1		Dary Llc	
04/24/07	$132,000	Wells Fargo Bk Na	CONVENTIONAL	YEARS	40		Bowen Vincent	
05/25/01	$171,477	Access Lndg Grp	CONVENTIONAL	YEARS	30		Trejo Rodolfo	

Foreclosure History

NOTICE OF TRUSTEE'S SALE

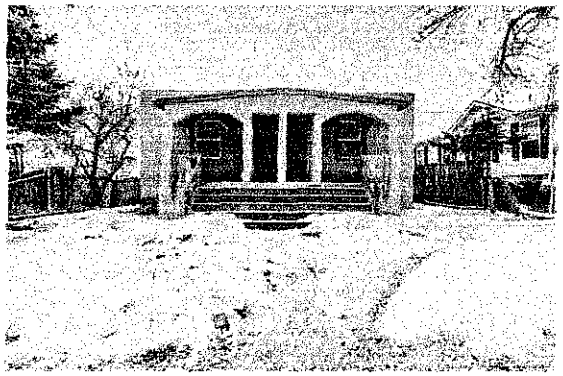
Document Type: **NOTICE OF TRUSTEE'S SALE**

Foreclosure Filing Dt: **06/10/2004**
Recording Date: **06/16/2004**
Document Number: **128360**
Page Number:
Default Amount:
Final Judgement Amt: **$168,062**
Original Document #: **85197**
Original Book/Page:
Lien Type:

Full Property View

3126 W 8th Avenue, Denver, CO 80204 — $724,900 - Active

Listing



Listing ID:	**9539510**	MLS Status:	**Active**
List Price:	**$724,900**	Original List Price:	**$724,900**
Property Type:	**Residential Income/Triplex**		
Levels:	***One***	*Basement:*	***Yes***
County:	**Denver**	Year Built:	**1940**
Subdivision Name:	**Villa Park**		
Listing Contract Date:	**03/06/2020**	Spec. Listing Cond:	**None Known**
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Annl:	**$0**
Tax Annual Amt:	**$2,671**	Tax Year:	**2019**
Tax Legal Desc:	**L 31 & W 22.052 FT L 32 INC S ACRE TRACT P T BARNUMS SUB**		

Exterior Area & SqFt

Building Area Total (SqFt Total):	**2,691**	Living Area (SqFt Finished):	**1,391**	Area Source:	**Public Records**
Above Grade Finished Area:	**1,391**				
Below Grade Total Area:	**1,300**	Below Grade Finished Area:	**0**	Below Grade Unfinished Area:	**1,300**
PSF Total:	**$269**	PSF Above Grade:	**$521**	PSF Finished:	**$521**

Basement:	**Full**	Bsmnt Ceiling Ht:	
Foundation Details:	***Slab***		
Heating:	**Forced Air**	# FP, FP Features	
Cooling:	**Central Air**		
Security Features:		Flooring:	**Carpet, Vinyl, Wood**
Appliances:	**Cooktop, Disposal, Refrigerator**		
Other Equipment:		Laundry:	**In Unit**
Exclusions:	**Staging furniture**		

Financials & Expenses

Cap Rate:	**7.10**	Cap Rate Calculation:	
Actual		Projected	
Gross Income:		Gross Income:	**52,800.00**
Operating Expense:		Annual Expense:	**10,351.00**
Annual Net Income:		Annual Net Income:	**42,449.00**

Operating Expense Includes: **Insurance, Real Estate Tax, Utilities**

Units Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
4 Bedroom Or More	**1**	**$1,600**		**2**	**4**	**1**				**1**	**1**	**1**				
2 Bedroom	**1**	**$1,200**		**1**	**2**	**1**				**1**	**1**	**1**				
3 Bedroom	**1**	**$1,600**		**1**	**3**	**1**				**1**	**1**	**1**				

Parking

Parking Total: **4** Garage Spaces: **3** Offstreet Spaces: **1**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	**1**			
Garage (Detached)	**3**			

Site & Location Information

Lot Size:	**0.13 Acres / 5,860 SqFt**	Fencing:	**Full**
Lot Features:	**Level**		
Road Responsibility:	**Public Maintained Road**		
		Elementary School:	**Eagleton / Denver 1**
Bldg/Complex Name:		Middle/Junior Sch:	**Strive Lake / Denver 1**
		High School:	**North / Denver 1**
Parcel Number:	**5082-01-012**	School of Choice:	
Is Incorporated:		*Zoning:*	***E-SU-D***
Walk Score:	**72**	**View Walk, Bike, & Transit Scores**	
Distance To Bus:	**3 Blocks**	Distance To Light Rail:	

Building Information

Architectural Style:

Entry Level/Loc: **1** Common Walls: **No One Above, No One Below**
Construction Materials: **Stucco**
Roof: **Membrane** Exterior Features:
Property Condition: **Updated/Remodeled** Builder Name: Builder Model:
Patio/Porch Feat: ***Covered, Front Porch*** *Pool Features:*

Water & Utilities

Water Source: **Public** Sewer: **Public Sewer**
Utilities: **Electricity Connected** Electric:

Public Remarks

Remodeled Triplex ready for lease up. 3 types of unit mix. All new vinyl plank in the basement with refinished hardwoods on the main level. All kitchens and bathrooms have been completely remolded with new appliance in all units. Each unit has there own dedicated laundry hookup. 3 individually separated garages and 1 off street parking.

Directions

Take Federal Blvd towards 8th Ave, on 8th Ave head west and take the right at the road split, property will be on your left.

Confidential Information

Private Remarks: **Please call listing agent before submitting any offer, all offers must be accompanied by a lender letter or POF**

Buyer Agency Comp: **2.8%** Dual Variable: **Yes** Submitted Prosp: **Yes**
Transaction Broker Comp: **2.0%**
Contract Earnest Check To: **Canyon Title** Possession:
Contract Min Earnest: **$5,000** Listing Terms: **Cash, Conventional, FHA, VA Loan**
Title Company: **Canyon Title** Ownership: **Individual**

Showing Information

Showing Contact Phone: **3035737469** Show Email: No Showings Until:
Showing Instructions: **Tenant in unit 3126 will provide access to his unit and also basement unit.**

List Agent

List Agent: David Ma *Phone:* **303-513-1374**
List Agent ID: **21136N** *Mobile:* **303-513-1374**
Office: **303-219-0210**
List Office: Signature Real Estate Corp. *Email:* mateam@resignature.com List Office ID: **SIGN1**

Generated on:
06/05/2020 9:22:50 AM

Tax

Characteristics

Lot Acres:	**0.135**	Lot Sq Ft:	**5,860**
Land Use - County:	**Apartment 2-8 Units**	Land Use - CoreLogic:	**Apartment**
Year Built:	**1940**	Bldg Sq Ft - Basement:	**700**
Bldg Sq Ft - Total:	**2,091**	Bldg Sq Ft - Finished:	**2,091**
Basement Type:	**Basement**	# Buildings:	**1**
Total Rooms:	**14.000**	Bedrooms:	**8**
Stories:	**1.0**	Heat Type:	**Hot Air**
Garage Type:	**Detached Garage**	Garage Capacity:	**0**
Garage Sq Ft:	**667**	Pool:	**CONCRETE**
Pool Size:	**260**	Quality:	**AVERAGE**

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Covrd Porch	**S**	**78**			
Swm Pl-Reinf Cn	**S**	**260**			
Det Garage-Msn	**S**	**667**			

Owner Information

Owner Name: **Ramirez Marco** Mailing Address: **1498 S Grand Baker Cir**
Mailing City & State: **Aurora Co** Mailing Zip: **80018**

Mailing ZIP 4:	**6046**	Mailing Carrier Route:	**R033**
Owner Occupied:	**No**		

Location Information

Property Zip:	**80204**	Property Zip4:	**3207**
Property Carrier Route:	**C024**	School District:	**Denver County 1**
Elementary School:	**EAGLETON**	Middle School:	**STRIVE LAKE**
High School:	**NORTH**	Subdivision:	**Subdivision Of Pt Of P T Barnums Sub To Denver**
Zoning:	**E-SU-D**	Census Tract:	**000905**
Topography:	**FLAT/LEVEL**	Neighborhood Code:	**0509**
Onboard Neighborhood Description:	**VILLA PARK**	Traffic:	**Graded**
		Township Range and Section:	***4S6808***
Quarter:	**NW**	Lot:	**31**

Tax Information

PIN:	**5082-01-012**	Alternate PIN:	**161199859**
Schedule Number:	**0508201012000**	% Improved:	**79**
Tax District:	**DENV**		
Legal Description:	**L 31 & W 22.052 FT L 32 INC 5 ACRE TRACT P T BARNUMS SUB**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$110,800**	**$87,400**	**$87,400**
Market Value - Improved	**$407,200**	**$292,200**	**$292,200**
Market Value - Total	**$518,000**	**$379,600**	**$379,600**
Assessed Value - Land	**$7,920**	**$6,290**	**$6,290**
Assessed Value - Improved	**$29,120**	**$21,040**	**$21,040**
Assessed Value - Total	**$37,040**	**$27,330**	**$27,330**
YOY Assessed Change ($)	**$9,710**	**$**	
YOY Assessed Change (%)	**36%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$2,671.18**	**$2,114.39**	**$2,108.07**
Change ($)	**$557**	**$6**	
Change (%)	**26%**	**0%**	

Last Market Sale

Sale Date:	**10/14/2019**	Price per SqFt - Finished:	**$184.12**
Document Number:	**000000233069**	Deed Type:	**Warranty Deed**
Owner Name:	**Ramirez Marco**	Seller Name:	**Schutrumpf Patience**

History

Listing History from MLS

ListingID: 9539510 Sts: Active
Parcel #: 5082-01-012

3126 W 8th Avenue, Denver, CO 80204
Residential Income, Triplex

LA: David Ma
LO: Signature Real Estate Corp.

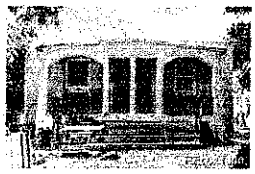
Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
03/06/2020	*New Listing*	*ACT-> $724,900*	*03/06/20 - 07:28 AM*	

ListingID: 7239457 Sts: Closed
Parcel #: 5082-01-012

3126 W 8th Avenue, Denver, CO 80204
Residential Income, Triplex

LA: Malisa Miller Eakins
LO: West And Main Homes Inc

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS



10/15/2019	Closed	($385,000)	10/16/19 - 04:58 PM	62
09/19/2019	Pending	ACT->PND	09/21/19 - 09:03 AM	62
08/28/2019	Back On Market	PND->ACT	08/28/19 - 08:36 PM	39
08/12/2019	Pending	ACT->PND	08/13/19 - 05:37 PM	39
07/15/2019	Back On Market	PND->ACT	07/15/19 - 04:29 PM	11
07/01/2019	Pending	ACT->PND	07/02/19 - 09:10 AM	11
06/21/2019	New Listing	ACT-> $400,000	06/21/19 - 07:31 PM	

ListingID: 763519 Sts: Closed
Parcel #:

3126 W 8Th Avenue, Denver, CO 80204
Residential Income, Triplex

LA: Key Alliance Team
LO: Sellstate Key Properties

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
07/07/2009	Closed	($99,900)	07/07/09 - 10:32 AM	
05/06/2009	Pending	ACT->PND	05/06/09 - 06:17 PM	
04/20/2009	New Listing	ACT-> $167,600	04/20/09 - 10:20 AM	

Sale History from Public Records

Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
10/14/19	$385,000		Ramirez Marco	Schutrumpf Patience	142541	Warranty Deed	Unified Title Co Inc	
01/07/15		Y	Schutrumpf Patience	3126 West 8th Avenue Trust	3966	Special Warranty Deed		
10/23/09		Y	3126 West 8th Avenue Trust	Schutrumpf Fleming & Patience	140433	Quit Claim Deed		
07/02/09	$99,900		Schutrumpf Fleming & Patience Schutrumpf Patience	Banco Popular North America	88950	Special Warranty Deed	Title America	
[illegible]		Y	[illegible] America	[illegible] Denver County	[illegible]	[illegible] Deed		
10/24/06	$310,000		Rodriguez Florentino Tejeda Francisco	Casillas Jose & Rosa M	177650	Warranty Deed	Land Title Guarantee	
10/01/01	$205,000		Casillas Jose & Rosa M Casillas Rosa M	Aguilar Teodoro	167053	Warranty Deed	First American Heritage Title	
10/01/00		Y	Aguilar Teodoro	Aguilar Teodoro	157975	Quit Claim Deed	Transnation Title Ins Co	

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate	Int Rate Type	Borrower Name(s):	Title Company
10/14/19	$335,000			YEARS	1			Ramirez Marco	
10/29/13	$200,000	Citywide Banks	CONVENTIONAL				ADJUSTABLE INT RATE LOAN	3126 West 8th Avenue Trust	
07/14/09	$65,000	Firstbank/South Jefferson	CONVENTIONAL	YEARS	30	5.625	ADJUSTABLE INT RATE LOAN	Schutrumpf Fleming Schutrumpf Patience	
[illegible]	[illegible]	North America	[illegible]	[illegible]	[illegible]	[illegible]	INT RATE LOAN	Tejeda Francisco	
10/03/01	$164,000	Absolute Lending Inc	CONVENTIONAL	YEARS	30			Casillas Jose Casillas Rosa M	
10/27/00	$110,000	American Pioneer Fin'l Svcs	CONVENTIONAL	YEARS	30		ADJUSTABLE INT RATE LOAN	Aguilar Teodoro	
10/23/96	$93,641	Denver Mtg Co	FHA					Aguilar Teodoro Aguilar Chico U C	

Foreclosure History

CERTIFICATE OF PURCHASE

Document Type: **CERTIFICATE OF PURCHASE**
Default Date:
Foreclosure Filing Dt:
Recording Date: **10/12/2007**
Document Number: **160351**
Book Number:
Page Number:
Default Amount:
Final Judgement Amt:
Original Doc Date: **11/06/2006**
Original Document #: **177651**
Original Book/Page:
Lien Type:

NOTICE OF TRUSTEE'S SALE

Default Date:
Foreclosure Filing Dt: **08/06/2007**
Book Number:
Page Number:
Original Doc Date: **11/06/2006**
Original Document #: **177651**

1295 Vance Street, Lakewood, CO 80214 — $700,000 - Active

Listing

Listing ID:	5350723	MLS Status:	Active
List Price:	$700,000	Original List Price:	$700,000
Property Type:	Residential Income/Triplex		
Levels:	One	Basement:	Yes
County:	Jefferson	Year Built:	1950
Subdivision Name:	Two Creeks		
Listing Contract Date:	06/01/2020	Spec. Listing Cond:	None Known
Association: N Multiple: Cov/Rest: N		Assoc Fee Tot Annl:	$0
Tax Annual Amt:	$2,707	Tax Year:	2019
Tax Legal Desc:	SECTION 02 TOWNSHIP 04 RANGE 69 QTR NE SUBDIVISIONCD 442600 SUBDIVISIONNAME LAKEWOOD BLOCK 059 LOT SIZE: 8760 TRACT 00F VALUE: .201 SECTION 02 TOWNSHIP 04 RANGE 69 QTR NE SUBDIVISIONCD 442600 SUBDIVISIONNAME LAKEWOOD BLOCK 059 LOT SIZE: 240 TRACT 0SF VALUE: .006		

Recent: 06/01/2020 : NEW

Interior Area & SqFt

Building Area Total (SqFt Total):	2,484	Living Area (SqFt Finished):	2,400	Area Source:	Public Records
Above Grade Finished Area:	1,594				
Below Grade Total Area:	890	Below Grade Finished Area:	806	Below Grade Unfinished Area:	84
PSF Total:	$282	PSF Above Grade:	$439	PSF Finished:	$292

Basement: **Finished, Walk-Out Access**
Bsmnt Ceiling Ht:
Heating: **Forced Air**
FP, FP Features
Cooling: **Central Air**
Interior Features: **Ceiling Fan(s), No Stairs**
Security Features: **Carbon Monoxide Detector(s), Smoke Detector(s)**
Flooring: **Carpet, Linoleum, Wood**
Appliances: **Dishwasher, Disposal, Dryer, Gas Water Heater, Refrigerator, Self Cleaning Oven, Tankless Water Heater, Washer**
Other Equipment:
Laundry: **In Unit**
Exclusions: **Black stainless steel refrigerator in Unit B. Black stainless steel refrigerator and washer and dryer in 7402 W 13th Ave. All personal property in all three units.**

Financials & Expenses

Cap Rate: **5.20**
Cap Rate Calculation:

Actual		*Projected*	
Gross Income:		Gross Income:	42,180.00
Operating Expense:		Annual Expense:	5,587.00
Annual Net Income:		Annual Net Income:	6,053.00

Operating Expense Includes: **Insurance, Maintenance, Personal Property Tax**
Owner Pays: **Insurance, Taxes, Water**
Utility Billing To Tenants: **Direct Billing from Utility**
Tenant Pays: **Cable TV, Electricity, Gas, Internet, Telephone, Trash Collection**
Utility Metering: **Common Electric, Common Gas, Common Water, Separate Electric, Separate Gas**

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
2 Bedroom	1	$1,200		1	2	1	1			1			1		1	
1 Bedroom	1	$1,100	890	1	1	1	1			1	1	1	1		1	
2 Bedroom	1	$1,400		1	2	1	1	1	1		1	1	1		1	Updated

Parking

Parking Total: **4**
Garage Spaces: **1**
Offstreet Spaces: **3**

Parking Type	*# of Spaces*	*Parking Length*	*Parking Width*	*Parking Description*
Off-Street	**3**			
Garage (Attached)	**1**			**Oversized 1 car garage, 4 parking space in drivewa**

Parking Features: **Concrete**

Site & Location Information

Lot Size: **0.21 Acres / 9,000 SqFt**
Fencing: **Full**
Lot Features: **Corner Lot, Level, Near Public Transit**
Road Responsibility: **Public Maintained Road**
Elementary School: **Molholm / Jefferson County R-1**
Middle/Junior Sch: **Creighton / Jefferson County R-1**
Bldg/Complex Name:
High School: **Lakewood / Jefferson County R-1**
Parcel Number: **212452**
School of Choice:

Walk Score: **65** View Walk, Bike, & Transit Scores
Distance To Bus: **1 Blocks** Distance To Light Rail: **1 Blocks**

Building Information

Architectural Style:
Construction Materials: **Brick**
Roof: **Composition** Exterior Features: **Private Yard**
Property Condition: **Updated/Remodeled** Builder Name: Builder Model:
Patio/Porch Feat: **Front Porch, Patio** Pool Features:

Water & Utilities

Water Source: **Public** Sewer: **Public Sewer**
Utilities: **Cable Available** Electric: **220 Volts**

Outbuildings

Outbuilding Type	SqFt	Stories	Yr Blt	Stalls	Doors	Length/Width	Floor	Stall Floor	Features	Description

Public Remarks

Location and updates in this 5 bedroom, 3 bathroom triplex make it the perfect investment property. Located just one *block east of Wadsworth light rail station. Two 2 bedroom, 1 bath units and one 1 bedroom, 1 bath unit that sits below the* front unit. Front unit is fully updated with new kitchen appliances, new carpet and engineered hardwood floors, updated bathroom, new windows, new doors and new paint. One bedroom, one bath unit has all new electrical, new plumbing, new engineered hardwood flooring, updated bathroom, new windows and new doors. All units have new furnaces, hot water heaters, and central air conditioning. Main water line was replaced in 2019. Each unit has their own laundry room and separate yard. There are storage areas inside the garage for each unit and storage shed in the backyard of third unit. The roof was replaced in 2016. Basement is non conforming. Plenty of parking with 3 parking spots on the street and 4 parking spots in the driveway. Ready to rent or live in one unit and rent out the other two. Or use as a single family residence with the mother-in-law unit on the side.

Confidential Information

Private Remarks: **Agent is related to the seller and has an interest in the property. Please comply with COVID 19 guidelines. *Wear masks when inside the properties and limit showings to licensed agent and buyers. Only 1295 Vance Street Unit A* and B are to be shown. 7402 W. 13th Avenue will be shown after accepted contract. No sign at this time, will be up by Friday. One hour notice for showings.**

Buyer Agency Comp: **2.8%** Dual Variable: **No** Submitted Prosp: **No**
Transaction Broker Comp: **2.8%**
Contract Earnest Check To: **Land Title Guarantee Company** Possession: **Negotiable**
Contract Min Earnest: **$10,000** Listing Terms: **Cash, Conventional, Other**
Title Company: **Land Title Guarantee Company** Ownership: **Individual**

Showing Information

Showing Instructions: **Showings through Showingtime.com. Comply with COVID 19 guidelines. Please wear masks when inside and limit showings to licensed agent and buyers. Lights will be on and doors open. Please try not to touch anything. Showings of 1295 Vance St Unit A and Unit B only. 7402 W 13th Ave to be shown only after accepted contract. One hour notice for showings.**
Occupant Type: **Owner**

List Agent

List Agent: Cheryl Carey
List Agent ID: **55045416**
List Office: Signature Realty
Phone: **720-281-5256**
Office: **720-495-4846**
Email: cherylcarey41@gmail.com
List Office ID: **JBSSR**

Generated on:
06/05/2020 9:22:52 AM

Tax

Characteristics

Lot Acres:	**0.207**	Lot Sq Ft:	**9,000**
Land Use - CoreLogic:	**Sfr**	Building Type:	**Triplex**
Style:	**RANCH**	Year Built:	**1950**
Bldg Sq Ft - Above Ground:	**1,594**	Bldg Sq Ft - Basement:	**890**
Bldg Sq Ft - Finished Basement:	**801**	Bldg Sq Ft - Unfinished Basement:	**89**
Bldg Sq Ft - Total:	**2,484**	Bldg Sq Ft - Finished:	**1,594**
Bldg Sq Ft - 1st Floor:	**1,594**	Basement Type:	**Partial Finished**
# Buildings:	**1**	Bedrooms:	**5**
Baths - Total:	**3**	Baths - Full:	**3.000**
Stories:	**1.0**	Cooling Type:	**Evap Cooler**

Heat Type:	**Forced Air**	Garage Type:	**Attached Garage**
Garage Capacity:	**0**	Garage Sq Ft:	**500**
Construction:	**Masonry**	Water:	**TYPE UNKNOWN**
Sewer:	**Type Unknown**	Quality:	**AVERAGE**

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
First Floor	**S**	**1,594**			
Basement Total	**S**	**890**			
Attached Garage	**S**	**500**			
Enclosed Porch	**S**	**100**			
Covered Porch	**S**	**80**			

Owner Information

Owner Name:	**Lund Denise M**	Mailing Address:	**1295 Vance St**
Mailing City & State:	***Lakewood Co***	*Mailing Zip:*	***80214***
Mailing ZIP 4:	**4265**	Mailing Carrier Route:	**C023**
Owner Occupied:	**Yes**		

Location Information

Property Zip:	**80214**	Property Zip4:	**4265**
Property Carrier Route:	**C023**	School District:	**Jefferson County R-1**
Elementary School:	**MOLHOLM**	Middle School:	**CREIGHTON**
High School:	**LAKEWOOD**	Subdivision:	**Lakewood**
Census Tract:	**011550**	Topography:	**FLAT/LEVEL**
Neighborhood Code:	**3001**	Onboard Neighborhood Description:	**TWO CREEKS**
Township Range and Section:	**046902**	Quarter:	**NE**
		Block:	**59**
Lot:	**59**		

Tax Information

PIN:	**212452**	Alternate PIN:	**49-021-17-028**
Schedule Number:	**212452**	% Improved:	**81**
Tax District:	**7814**		
Legal Description:	**SECTION 02 TOWNSHIP 04 RANGE 69 QTR NE SUBDIVISIONCD 442600 SUBDIVISIONNAME LAKEWOOD BLOCK 059 LOT SIZE: 8760 TRACT 00F VALUE: .201 SECTION 02 TOWNSHIP 04 RANGE 69 QTR NE SUBDIVISIONCD 442600 SUBDIVISIONNAME LAKEWOOD BLOCK 059 LOT SIZE: 240 TRACT 0SF VALUE: .006**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$82,442**	**$77,948**	**$77,948**
Market Value - Improved	**$341,134**	**$231,863**	**$231,863**
Market Value - Total	**$423,576**	**$309,811**	**$309,811**
Assessed Value - Land	**$5,895**	**$5,612**	**$5,612**
Assessed Value - Improved	**$24,391**	**$16,694**	**$16,694**
Assessed Value - Total	**$30,286**	**$22,306**	**$22,306**
YOY Assessed Change ($)	**$7,980**	**$**	
YOY Assessed Change (%)	**36%**	**0%**	

Tax Year	2019	2018	2017
Total Tax	**$2,707.06**	**$2,061.48**	**$1,811.74**
Change ($)	**$646**	**$250**	
Change (%)	**31%**	**14%**	

Last Market Sale

Sale Date:	**01/15/2019**	Price per SqFt - Finished:	**$316.81**
Document Number:	**0000F1719544**	Deed Type:	**Warranty Deed**
Owner Name:	**Lund Denise M**	Seller Name:	**Brownfield Fred & Beverly**

History

Listing History from MLS

ListingID: 5350723 Sts: Active
Parcel #: 212452

1295 Vance Street, Lakewood, CO 80214
Residential Income, Triplex

LA: Cheryl Carey
LO: Signature Realty

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
06/01/2020	New Listing	ACT-> $700,000	06/01/20 - 08:26 AM	

ListingID: 9604595 Sts: Expired
Parcel #: 212452

1295 Vance Street, Lakewood, CO 80214
Residential Income, Triplex

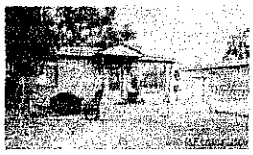
LA: Cheryl Carey
LO: Legacy Realty

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
04/30/2020	Expired	WTH->EXP	05/01/20 - 12:10 AM	17
11/30/2019	Withdrawn	ACT->WTH	11/30/19 - 03:47 PM	17
11/13/2019	New Listing	ACT-> $750,000	11/13/19 - 02:02 PM	

ListingID: 7978705 Sts: Closed
Parcel #: 212452

1295 Vance Street, Lakewood, CO 80214
Residential Income, Triplex

LA: Patrick Rampi
LO: Brokers Guild Classic



Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
01/15/2019	Closed	($505,000)	01/15/19 - 04:43 PM	85
11/09/2018	Pending	WTH->PND	11/09/18 - 11:05 PM	85
10/28/2018	Withdrawn	ACT->WTH	10/28/18 - 07:06 PM	85
10/16/2018	Back On Market	PND->ACT	10/16/18 - 03:43 PM	78
10/05/2018	Pending	ACT->PND	10/10/18 - 05:31 PM	78
08/22/2018	Price Decrease	$565,000->$530,000	08/22/18 - 10:46 AM	29
07/24/2018	New Listing	ACT-> $565,000	07/24/18 - 07:50 AM	

Sale History from Public Records

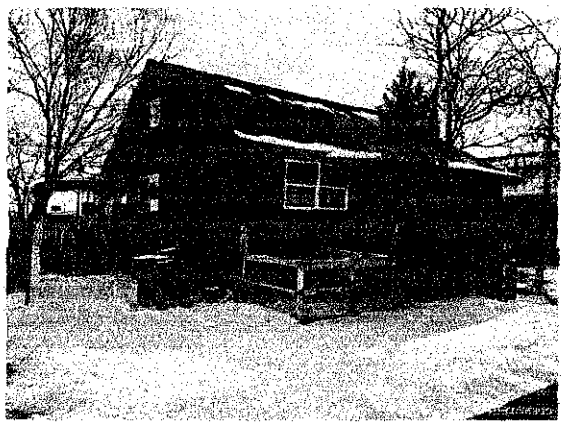
Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
01/15/19	$505,000		Lund Denise M	Brownfield Fred & Beverly	4095	Warranty Deed	Fidelity National Title Insura	
04/17/98	$178,000		Brownfield Fred & Beverly Brownfield Beverly	Kapsalakis Dean M	F0615451	Warranty Deed	Stewart Title	
05/01/91	$85,320		Troy & Nichols Inc	Phillips Helen	91036342	Public Trustees Deed		
06/05/90		Y	Herlein Gloria C & Kathleen M Herlein Kathleen M	Herlein Gloria C	90048072	Quit Claim Deed		
02/23/90	$121,900		Herlein Gloria C	Weinkauf Lew A & Ronald	90018311	Warranty Deed		
06/02/86	$122,900		Weinkauf Lew A	Thyfault David A	86082629	Warranty Deed		
06/23/86	$125,650		Roddam Thomas C	Butz Jerry D	86081254	Warranty Deed		
02/28/86	$125,650		Oddam Thomas C	Butz Jerry D	86023651	Warranty Deed		

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate	Int Rate Type	Borrower Name(s):	Title Company
01/16/19	$375,000	Nations Reliable Lndg Llc	CONVENTIONAL	YEARS	30			Lund Denise M	

4180 N Kalamath Street, Denver, CO 80211 — $695,000 - Active

Listing



Listing ID:	**2056478**	MLS Status:	**Active**
List Price:	**$695,000**	Original List Price:	**$750,000**
Property Type:	**Residential Income/Triplex**		
Levels:	**Two**	Basement:	**Yes**
County:	**Denver**	Year Built:	**1974**
Subdivision Name:	**Sunnyside**		
Listing Contract Date:	**04/13/2020**	Spec. Listing Cond:	**None Known**
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Annl:	**$0**
Tax Annual Amt:	**$3,886**	Tax Year:	**2019**
Tax Legal Desc:	**L 1 TO 3 INC BLK 18 VIADUCT ADD**		

Recent: 06/02/2020 : DOWN : $750,000->$695,000

Interior Area & SqFt

Building Area Total (SqFt Total):	**4,533**	Living Area (SqFt Finished):	**4,080**	Area Source:	**Public Records**
Above Grade Finished Area:	**2,589**				
Below Grade Total Area:	**1,944**	Below Grade Finished Area:	**1,491**	Below Grade Unfinished Area:	**453**
PSF Total:	**$153**	PSF Above Grade:	**$268**	PSF Finished:	**$170**

Basement: **Full** Bsmnt Ceiling Ht:
Heating: **Forced Air** # FP, FP Features
Cooling: **None**
Exclusions: **tenants personal property**

Financials & Expenses

Cap Rate: **4.60** Cap Rate Calculation: **in place cap rate**

Actual		Projected	
Gross Income:	**36,000.00**	Gross Income:	**60,000.00**
Operating Expense:	**6,000.00**	Annual Expense:	**9,000.00**
Annual Net Income:	**30,000.00**	Annual Net Income:	**51,000.00**

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
2 Bedroom	**3**	**$1,000**	**1,511**	**2**	**2**	**1**										**1 1/2 story units with basements**

Parking

Parking Total: **6** Garage Spaces: **0** Offstreet Spaces: **6**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	**6**			**off alley**

Site & Location Information

Lot Size: **0.22 Acres / 9,370 SqFt** Fencing:
Lot Features: **Level**

Elementary School: **Horace Mann E-8 / Denver 1**
Bldg/Complex Name: Middle/Junior Sch: **Strive Sunnyside / Denver 1**
High School: **North / Denver 1**
Parcel Number: **2214-19-018** School of Choice: **Yes**
Is Incorporated: **Yes** Zoning: **U-TU-C**
Walk Score: **74** View Walk, Bike, & Transit Scores
Distance To Bus: Distance To Light Rail: **3 Blocks**

Building Information

Architectural Style:
Direction Faces: **Northwest** View:
Construction Materials: **Frame, Vinyl Siding**
Roof: **Composition** Exterior Features:
Property Condition: **Fixer** Builder Name: Builder Model:

Water & Utilities

Water Source: **Public** Sewer:

Public Remarks

Excellent investment opportunity in the Sunnyside neighborhood just blocks from the 41st & Fox light rail station surrounded by new and planned urban infill development. This 9375 sq ft lot is zoned U-TU-C and features an existing triplex with each unit at ~1500 sq ft 2BD/1BA and ~4500+ total sq ft. Gross income is $3000/mo with tenants on month

to month leases. Buy/hold, renovate/split/sell, or build a new triplex. Another option is to scrape and split into two SFR lots. Call to discuss opportunity today.

Confidential Information

Private Remarks: **Do not disturb tenants. No showings without accepted contract. Listing broker has already had meeting with CPD on rezone so please call to discuss. Powerpoint is uploaded in supplements.**

Buyer Agency Comp:	**2.80%**	Dual Variable:	**No**	Submitted Prosp:	**No**
Transaction Broker Comp:	**2.80%**				
Contract Earnest Check To:	**Stewart Title**			Possession:	**Closing/DOD**
Contract Min Earnest:	**$20,000**	Listing Terms:	**Cash, Conventional**		
Title Company:	**Stewart Title**			Ownership:	**Corporation/Trust**
Investor Blackout End Date:		Docs Available:		Home Warranty:	**No**

Showing Information

Showing Instructions: **Drive by one, please DO NOT disturb tenants. Showing will be arranged upon accepted contract.**
Occupant Type: **Tenant**

List Agent

List Agent: **Gearhart Moore Team**
List Agent ID: **50805T**
List Office: **MODUS Real Estate**
Co List Agent: **Charles Moore**
Co List Office: **MODUS Real Estate**

Phone: **303-747-3320**
Office: **303-974-4717**
Email: **gmteam@modusrealestate.com**
Phone: **303-305-9400**
Email: **CharlesM@Realtor.com**

List Office ID: **M2993**
Co List Agent ID: **34435N**
Co List Office ID: **M2993**

Generated on:
06/05/2020 9:22:54 AM

Tax

Characteristics

Lot Acres:	**0.215**	Lot Sq Ft:	**9,370**
Land Use - County:	**Apartment 2-8 Units**	Land Use - CoreLogic:	**Apartment**
Year Built:	**1974**	Bldg Sq Ft - Total:	**1,944**
Bldg Sq Ft - Finished:	**1,944**	# Buildings:	**1**
Total Rooms:	**9.000**	Bedrooms:	**3**
Stories:	**1.0**	Heat Type:	**Hot Air**
Patio Type:	**Concrete/Masonry Patio**	Garage Type:	**Parking Avail**
Garage Capacity:	**0**	Pool:	**GUNITE**
Pool Size:	**144**	Quality:	**AVERAGE**

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Swm Pl-Gunite	**S**	**144**			
Conc Patio	**S**	**144**			

Owner Information

Owner Name:	**Shannon Warren P**	Mailing Address:	**3501 E Virginia Ave**
Mailing City & State:	**Denver Co**	Mailing Zip:	**80209**
Mailing ZIP 4:	**3528**	Mailing Carrier Route:	**C036**
Owner Occupied:	**No**		

Location Information

Property Zip:	**80211**	Property Zip4:	**2522**
Property Carrier Route:	**C025**	School District:	**Denver County 1**
Elementary School:	**TREVISTA**	Middle School:	**STRIVE SUNNYSIDE**
High School:	**NORTH**	Subdivision:	**Viaduct Add To Denver**
Zoning:	**U-TU-C**	Census Tract:	**001101**
Topography:	**FLAT/LEVEL**	Neighborhood Code:	**0220**
Onboard Neighborhood Description:	**SUNNYSIDE**	Traffic:	**Local**

		Township Range and Section:	**3S6821**
Quarter:	**SE**	Block:	**18**
Lot:	**1**		

Tax Information

PIN:	**2214-19-018**	Alternate PIN:	**160740209**
Schedule Number:	**0221419018000**	% Improved:	**54**
Tax District:	**DENV**		
Legal Description:	**L 1 TO 3 INC BLK 18 VIADUCT ADD**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$349,200**	**$271,600**	**$271,600**
Market Value - Improved	**$404,500**	**$337,700**	**$337,700**
Market Value - Total	**$753,700**	**$609,300**	**$609,300**
Assessed Value - Land	**$24,970**	**$19,560**	**$19,560**
Assessed Value - Improved	**$28,920**	**$24,310**	**$24,310**
Assessed Value - Total	**$53,890**	**$43,870**	**$43,870**
YOY Assessed Change ($)	**$10,020**	**$**	
YOY Assessed Change (%)	**23%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$3,886.33**	**$3,394.00**	**$3,383.87**
Change ($)	**$492**	**$10**	
Change (%)	**15%**	**0%**	

Last Market Sale

Owner Name: **Shannon Warren P**

History

Listing History from MLS

ListingID: 2056478 Sts: Active
Parcel #: 2214-19-018

4180 N Kalamath Street, Denver, CO 80211
Residential Income, Triplex

LA: Gearhart Moore Team
LO: Modus Real Estate

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
06/02/2020	Price Decrease	$750,000->$695,000	06/02/20 - 08:43 AM	50
04/13/2020	New Listing	ACT-> $750,000	04/13/20 - 03:26 PM	

Sale History from Public Records

Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
12/11/18		Y	Shannon Warren P Trust	Shannon Warren P	157560	Quit Claim Deed		
04/12/74			Shannon Warren P & Shannon Lois Jean Shannon Lois Jean		863-229	Warranty Deed		

9615 W 6th Ave Frontage Road, Lakewood, CO 80215 — $695,000 - Active

Listing

Listing ID:	5847438	MLS Status:	Active
List Price:	$695,000	Original List Price:	$695,000
Property Type:	Residential Income/Triplex		
Levels:	Two	Basement:	No
County:	Jefferson	Year Built:	1918
Subdivision Name:	Lakewood Acres		
Listing Contract Date:	02/29/2020	Spec. Listing Cond:	None Known
Association: N Multiple:	Cov/Rest: N	Assoc Fee Tot Annl:	$0
Tax Annual Amt:	$2,141	Tax Year:	2018
Tax Legal Desc:	SECTION 03 TOWNSHIP 04 RANGE 69 QTR SW SUBDIVISIONCD 443000 SUBDIVISIONNAME LAKEWOOD ACRES BLOCK LOT 0001 SIZE: 25932 TRACT 00A VALUE: .595		

Interior Area & SqFt

Building Area Total (SqFt Total):	2,906	Living Area (SqFt Finished):	2,906	Area Source:	Public Records
Above Grade Finished Area:	2,906				
Below Grade Total Area:	0	Below Grade Finished Area:	0	Below Grade Unfinished Area:	0
PSF Total:	$239	PSF Above Grade:	$239	PSF Finished:	$239

Heating: **Electric, Forced Air, Hot Water, Natural Gas, Wall Furnace** # FP, FP Features

Cooling: **None**

Security Features: *Flooring:* ***Carpet, Linoleum***

Appliances: **Cooktop, Gas Water Heater, Oven, Refrigerator**

Exclusions: **None**

Financials & Expenses

Actual		Projected	
Gross Income:	50,280.00	Gross Income:	
Owner Pays:	Insurance, Taxes, Trash Collection, Water	Utility Billing To Tenants:	Direct Billing from Utility
Tenant Pays:	Electricity, Gas	Utility Metering:	Separate Electric, Separate Gas

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
2 Bedroom	1	$1,200			2	1				1	1	1				Single Family
2 Bedroom	1	$1,340			2	1		1	1		1	1				Duplex Unit
3 Bedroom	1	$1,650				1				1	1	1				Duplex Unit

Parking

Parking Total:	6	Garage Spaces:	1	Offstreet Spaces:	4
Carport Spaces:	1	Reserved Spaces:	0	RV Spaces:	0

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	4			
Carport (Attached)	1			
Garage (Detached)	1			

Parking Features: **220 Volts**

Size & Location Information

Lot Size: **0.60 Acres / 25,932 SqFt**

Lot Features: **Ditch**

Fencing: **Partial**

Bldg/Complex Name:

Elementary School: **Eiber / Jefferson County R-1**

Middle/Junior Sch: **Creighton / Jefferson County R-1**

High School: ***Lakewood / Jefferson County R-1***

Parcel Number: **054499**

Walk Score: **41**

School of Choice:

View Walk, Bike, & Transit Scores

Building Information

Architectural Style:

Direction Faces: ***South*** *View:*

Construction Materials: **Frame**

Roof: **Composition** Exterior Features:

Water & Utilities

Water Source: **Public** Sewer: **Public Sewer**

Utilities: Electric: **220 Volts**

Outbuildings

Outbuilding Type	SqFt	Stories	Yr Blt	Stalls	Doors	Length/Width	Floor	Stall Floor	Features	Description
Shed(s)										

Public Remarks

Lakewood Income property with huge lot and potential. Money making Duplex and quaint single family unit. All kitchen appliances are included. Over 1/2 acre with tons of space for parking or ? Great long-term renters in 2 units. EZ to Rent. Great location with 6th Ave access to Downtown or the Mountains. Call Keith for a private showing.

Directions

From Garrison and 6th Ave, take the one-way North 6th Ave Frontage road to the Property

Confidential Information

Private Remarks: **Seller owns 1 stackable washer and dryer. Buyer to verify intended use is acceptable. A licensee must accompany all Buyers during showings. No weekend deadlines or love letters from Buyers please. Lead Based Paint Disclosure can be found in supplements. All showing brokers must respond to the 5-question Health Questionnaire posted in Matrix Supplements and also available on ShowingTime. If any visitor answers 'Yes" to any of the questions, please reschedule for another time.**

Buyer Agency Comp:	**2.8%**	Dual Variable:	**Yes**	Submitted Prosp:	**No**
Contract Earnest Check To:	**RE/MAX 100 Inc**			Possession:	**Subject To Tenant Rights**
Contract Min Earnest:	**$12,000**	Listing Terms:	**Cash, Conventional**		
Title Company:	**First American**			Ownership:	**Individual**
Investor Blackout End Date:		Docs Available:		Home Warranty:	**No**

Showing Information

Showing Contact Phone:	**303-573-7469**	Show Email:	No Showings Until: **02/29/20**
Showing Instructions:	**Show only Unit 9617 in Duplex, the unit with the sign in the door. DO NOT DISTURB other tenants! In accordance with current COVID-19 guidelines, we are requesting the showing party be limited to one broker and two clients, with 6 feet of distance between parties at all times. Please wear a mask, gloves, and booties if possible and dispose of these items appropriately upon exiting the property. Please do not touch surfaces and please try to limit in-person showing times to 15 minutes if possible. All showing brokers must respond to the 5-question Health Questionnaire posted in Matrix Supplements and also available on ShowingTime. Please email or fax this signed questionnaire to Re/Max 100, Inc. If any visitor answers 'Yes" to any of the questions, please reschedule for another time.**		
Occupant Type:	**Tenant**		

List Agent

List Agent: Keith Hurtubise
List Agent ID: **100445**

Phone: **303-202-2221**
Mobile: **303-808-8202**
Office: **303-232-4444**
Email: keithabees@aol.com

List Office: RE/MAX 100 INC.
List Office ID: **REM12**

Generated on:
06/05/2020 9:22:56 AM

Tax

Characteristics

Lot Acres:	**0.595**	Lot Sq Ft:	**25,932**
Land Use - CoreLogic:	**Sfr**	Building Type:	**Duplex**
Year Built:	**1918**	Bldg Sq Ft - Above Ground:	**2,906**
Bldg Sq Ft - Finished:	**2,906**	Bldg Sq Ft - 1st Floor:	**1,582**
# Buildings:	**2**	Bedrooms:	**4**
Baths - Total:	**3**	Baths - Full:	**3.000**
Stories:	**1.5**	Heat Type:	**Wall Furnace**
Garage Type:	**Carport**	Garage Capacity:	**0**
Roof Material:	**Concrete**	Construction:	**Wood**
Water:	**TYPE UNKNOWN**	Sewer:	**Type Unknown**
Quality:	**FAIR**		

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Carport	**S**	**288**			**1918**
Res	**S**	**633**			

Detached	**S**	**75**
1/2 Story Total	**S**	**1,582**
Covered Porch	**S**	**288**
First Floor		
Carport		

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Detached Garage	**S**	**240**			
First Floor	**S**	**691**			

Owner Information

Owner Name:	**9615 Properties Llc**	Mailing Address:	**670 Garland St**
Mailing City & State:	**Lakewood Co**	Mailing Zip:	**80215**
Mailing ZIP 4:	**5856**	Mailing Carrier Route:	**C013**
Owner Occupied:	**No**		

Location Information

Property Zip:	**80215**	Property Zip4:	**5804**
Property Carrier Route:	**C014**	School District:	**Jefferson County R-1**
Elementary School:	**EIBER**	Middle School:	**CREIGHTON**
High School:	**LAKEWOOD**	Subdivision:	**Lakewood Acres**
Census Tract:	***011100***	*Neighborhood Code:*	***3003***
Onboard Neighborhood *Description:*	**NORTH KIPLING**	Township Range and *Section:*	**046903**
Quarter:	**SW**	Lot:	**1**

Tax Information

PIN:	**054499**	Alternate PIN:	**49-033-11-005**
Schedule Number:	***054499***	*% Improved:*	**78**
Tax District:	**7041**		
Legal Description:	**SECTION 03 TOWNSHIP 04 RANGE 69 QTR SW SUBDIVISIONCD 443000 SUBDIVISIONNAME LAKEWOOD ACRES BLOCK LOT 0001 SIZE: 25932 TRACT 00A VALUE: .595**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$101,784**	**$72,185**	**$72,185**
Market Value - Improved	**$353,381**	**$249,523**	**$249,523**
Market Value - Total	**$455,165**	**$321,708**	**$321,708**
Assessed Value - Land	**$7,278**	**$5,197**	**$5,197**
Assessed Value - Improved	**$25,267**	**$17,966**	**$17,966**
Assessed Value - Total	**$32,545**	**$23,163**	**$23,163**
YOY Assessed Change ($)	**$9,382**	**$**	
YOY Assessed Change (%)	**41%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$2,909.00**	**$2,140.70**	**$1,881.32**
Change ($)	**$768**	**$259**	
Change (%)	**36%**	**14%**	

Last Market Sale

Sale Date:	**09/10/2015**	Price per SqFt - Finished:	**$54.37**
Deed Type:	**Warranty Deed**	Owner Name:	**9615 Properties Llc**
Seller Name:	**Williamson Kathleen J**		

History

Listing History from MLS

ListingID: 5847438 Sts: Active **9615 W 6th Ave Frontage Road, Lakewood, CO 80215** LA: Keith Hurtubise
Parcel #: 054499 Residential Income, Triplex LO: Re/Max 100 Inc.

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
02/29/2020	New Listing	ACT-> $695,000	02/29/20 - 10:16 AM	

Sale History from Public Records

Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
10/21/15		Y	9615 Properties Llc	Thayer Richard S	113438	Quit Claim Deed		
09/10/15	$158,000		Thayer Richard S	Williamson Kathleen J	99021	Warranty Deed	Heritage Title Co.	
07/30/14		Y	Williamson Kathleen J	Williamson Andrew N Jr	62511	Deed Of Distribution	Attorney Only	
02/19/02		Y	Williamson Andrew N Jr	Moore Margaret J	F1429215	Quit Claim Deed		

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate	Int Rate Type	Borrower Name(s):	Title Company
07/13/16	$150,000		PRIVATE PARTY LENDER	YEARS	7	4	FIXED RATE LOAN	Thayer Richard S	Empire Title/Co Spgs Llc
06/14/00	$10,147	Commercial Fed Bk	CONVENTIONAL					Moore Margaret J	

1603 Harlan Street, Lakewood, CO 80214 — $525,000 - Active

Listing

Listing ID:	**4039929**	MLS Status:	**Active**
List Price:	**$525,000**	Original List Price:	**$525,000**
Property Type:	**Residential Income/Triplex**		
Levels:	**One**	Basement:	**Yes**
County:	**Jefferson**	Year Built:	**1954**
Subdivision Name:	**Edgewater**		
Listing Contract Date:	**04/02/2020**	Spec. Listing Cond:	**None Known**
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Annl:	**$0**
Tax Annual Amt:	**$3,167**	Tax Year:	**2019**

Tax Legal Desc: **SECTION 36 TOWNSHIP 03 RANGE 69 QTR SW SUBDIVISIONCD 218000 SUBDIVISIONNAME EDGEWATER BLOCK 025 LOT 0029 SIZE: 3325 TRACT VALUE: .076 SECTION 36 TOWNSHIP 03 RANGE 69 SUBDIVISIONCD 218000 SUBDIVISIONNAME EDGEWATER BLOCK 025 LOT 0030 SIZE: 3325 TRACT VALUE: .076 SECTION 36 TOWNSHIP 03 RANGE 69 SUBDIVISIONCD 218000 SUBDIVISIONNAME EDGEWATER BLOCK 025 LOT SIZE: 500 TRACT OSC VALUE: .011**

Recent: 05/29/2020 : Back On Market : P->A

Interior Area & SqFt

Building Area Total (SqFt Total):	**2,337**	Living Area (SqFt Finished):	**2,337**	Area Source:	**Appraiser**
Above Grade Finished Area:	**1,454**				
Below Grade Total Area:	**883**	Below Grade Finished Area:	**883**	Below Grade Unfinished Area:	**0**
PSF Total:	**$225**	PSF Above Grade:	**$361**	PSF Finished:	**$225**

Basement:	**Finished**	Bsmnt Ceiling Ht:	
Heating:	**Forced Air**	# FP, FP Features	**1/Living Room**
Cooling:	**Other**		
Security Features:		Flooring:	**Carpet, Laminate, Wood**
Appliances:	**Dishwasher, Disposal, Dryer, Oven, Refrigerator**		
Other Equipment:		Laundry:	**Common Area, Main Level**
Exclusions:	**Seller's Personal Property, Tenant's Personal Property, Flagstone outside of Carriage House, Clothes Washer**		

Financials & Expenses

Cap Rate:	**6.20**	Cap Rate Calculation:	
Actual		Projected	
Gross Income:	**32,100.00**	Gross Income:	**41,400.00**
Operating Expense:	**8,811.00**	Annual Expense:	**8,811.00**
Annual Net Income:	**23,289.00**	Annual Net Income:	**32,589.00**

Operating Expense Includes: **Insurance, Maintenance, Real Estate Tax, Utilities**

Owner Pays:	**Exterior Maintenance, Grounds Care, Insurance, Taxes, Water**	Utility Billing To Tenants:	**Direct Billing from Utility**
Tenant Pays:	**Cable TV, Electricity, Gas, Internet**	Utility Metering:	**Common Electric, Common Gas, Common Water**

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
Studio	**1**	**$585**	**571**	**2**	**1**	**1**	**1**		**1**	**2**	**1**	**1**				
1 Bedroom	**1**	**$1,100**	**883**	**2**	**1**	**1**	**1**		**1**	**2**	**1**	**1**				
2 Bedroom	**1**	**$990**	**883**	**2**	**2**	**1**	**1**		**1**	**2**	**1**	**1**				

Parking

Parking Total: **5** Garage Spaces: **1** Offstreet Spaces: **4**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	**4**			
Garage (Attached)	**1**			

Site & Location Information

Lot Size:	**0.16 Acres / 7,150 SqFt**	Fencing:	**Full**
Road Responsibility:	**Public Maintained Road**		
		Elementary School:	**Edgewater / Jefferson County R-1**
Bldg/Complex Name:		Middle/Junior Sch:	**Jefferson / Jefferson County R-1**
		High School:	**Jefferson / Jefferson County R-1**
Parcel Number:	**201822**	School of Choice:	
Is Incorporated:		Zoning:	**RES**
Walk Score:	**65**	View Walk, Bike, & Transit Scores	

Building Information

Architectural Style: **Contemporary**
Entry Level/Loc:
Direction Faces:
Construction Materials: **Frame**
Roof: **Composition**

Common Walls: **No Common Walls**
View: **City**
Exterior Features: **Private Yard**

Water & Utilities

Water Source: **Public**
Utilities: **Cable Available, Electricity Connected, Internet Access (Wired), Natural Gas Connected, Phone Available**

Sewer: **Public Sewer**
Electric:

Outbuildings

of Outbuildings: **2**

Public Remarks

Beautiful Tri-Plex in the Edgewater subdivision! 2 Bed / 1 Bath unit upstairs, 1 Bed / 1 Bath unit downstairs, and Studio Carriage House in Back. Shared laundry unit. Spacious backyard with two storage buildings. Tenants pay Gas/Electric & Cable/Internet. Plenty of parking with attached 1-Car Garage and multiple off-street parking spots. Great location close to Denver and Sloan's Lake. Virtual Tour 1: shorturl.at/zGSU6 Virtual Tour 2: shorturl.at/JTZ58 Exterior 360 Tour: shorturl.at/nqzLZ

Confidential Information

Private Remarks: **Previous Day Notice required for ALL showings. Tenants will step out for all showings. See virtual tours below: Virtual Tour 1: shorturl.at/zGSU6 Virtual Tour 2: shorturl.at/JTZ58 Exterior 360 Tour: shorturl.at/nqzLZ**

Buyer Agency Comp: **2.8%**
Transaction Broker Comp: **2.8%**
Contract Earnest Check To: **Guardian Title**
Contract Min Earnest: **$5,000**
Title Company: **Guardian Title**
Investor Blackout End Date:

Dual Variable: **No**
Listing Terms: **Cash, Conventional, VA Loan**
Docs Available: **Lead Based Paint, Leases, Utility Average**

Submitted Prosp: **No**
Possession: **Closing/DOD**
Ownership: **Individual**
Home Warranty:

Showing Information

Showing Contact Phone: **303-573-7469**
Showing Instructions: **ShowingTime. Previous Day Notice Required for All Showings**
Occupant Type: **Tenant**

Show Email:

No Showings Until:

List Agent

List Agent: James Stewart
List Agent ID: **028597**

Phone: **970-290-3755**
Mobile: **970-290-3755**
Office: **970-223-6500**

List Office: COLDWELL BANKER RES BROKERAGE
Email: jimmystewart@nocohomes.net
List Office ID: **CBRFC**

Generated on:
06/05/2020 9:23:00 AM

Tax

Characteristics

Lot Acres:	**0.164**	Lot Sq Ft:	**7,150**
Land Use - CoreLogic:	**Sfr**	Building Type:	**Single Family**
Style:	**RANCH**	Year Built:	**1954**
Bldg Sq Ft - Above Ground:	**1,324**	Bldg Sq Ft - Basement:	**894**
Bldg Sq Ft - Finished Basement:	**894**	Bldg Sq Ft - Total:	**1,788**
		Bldg Sq Ft - Finished:	**1,324**
Bldg Sq Ft - 1st Floor:	**894**	Basement Type:	**Finished**
# Buildings:	**2**	Bedrooms:	**2**
Baths - Total:	**3**	Baths - Full:	**3.000**
Stories:	**1.0**	Fireplace:	**Y**
Fireplaces:	**1**	Heat Type:	**Forced Air**
Garage Type:	**Attached Garage**	Garage Capacity:	**0**
Garage Sq Ft:	**247**	Construction:	**Wood**
Water:	**TYPE UNKNOWN**	Sewer:	**Type Unknown**
Quality:	**FAIR**		

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Basement Total	**S**	**894**			
Covered Porch	**S**	**63**			
First Floor	**S**	**894**			
Attached Garage	**S**	**247**			

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Enclosed Porch	**S**	**139**			
First Floor	**S**	**430**			

Owner Information

Owner Name:	**Aberly Scott T**	Owner Name 2:	**Aberly Sylvia**
Mailing Address:	**8017 Sunrise Ct**	Mailing City & State:	**Erie Co**
Mailing Zip:	**80516**	Mailing ZIP 4:	**9422**
Mailing Carrier Route:	**R001**	Owner Occupied:	**No**

Location Information

Property Zip:	**80214**	Property Zip4:	**1525**
Property Carrier Route:	**C032**	School District:	**Jefferson County R-1**
Elementary School:	**EDGEWATER**	Middle School:	**JEFFERSON**
High School:	**JEFFERSON**	Subdivision:	**Edgewater**
Census Tract:	**011401**	Neighborhood Code:	**2411**
Onboard Neighborhood Description:	**EDGEWOOD**	Township Range and Section:	**036936**
Quarter:	**SW**	Block:	**25**
Lot:	**29**		

Tax Information

PIN:	**201822**	Alternate PIN:	**39-363-09-016**
Schedule Number:	**201822**	% Improved:	**54**
Tax District:	**7031**		
Legal Description:	**SECTION 36 TOWNSHIP 03 RANGE 69 QTR SW SUBDIVISIONCD 218000 SUBDIVISIONNAME EDGEWATER BLOCK 025 LOT 0029 SIZE: 3325 TRACT VALUE: .076 SECTION 36 TOWNSHIP 03 RANGE 69 SUBDIVISIONCD 218000 SUBDIVISIONNAME EDGEWATER BLOCK 025 LOT 0030 SIZE: 3325 TRACT V ALUE: .076 SECTION 36 TOWNSHIP 03 RANGE 69 SUBDIVISIONCD 218000 SUBDIVISIONNAME EDGEWATER BLOCK 025 LOT SIZE: 500 TRACT OSC VALUE: .011**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$226,348**	**$170,782**	**$170,782**
Market Value - Improved	**$265,487**	**$273,617**	**$273,617**
Market Value - Total	**$491,835**	**$444,399**	**$444,399**
Assessed Value - Land	**$16,184**	**$12,296**	**$12,296**
Assessed Value - Improved	**$18,982**	**$19,700**	**$19,700**
Assessed Value - Total	**$35,166**	**$31,996**	**$31,996**
YOY Assessed Change ($)	**$3,170**	**$**	
YOY Assessed Change (%)	**10%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$3,167.14**	**$2,980.82**	**$2,622.58**
Change ($)	**$186**	**$358**	
Change (%)	**6%**	**14%**	

Last Market Sale

Sale Date:	**07/31/1996**	Price per SqFt - Finished:	**$94.37**
Document Number:	**000000070897**	Sale Type:	**Full**
Deed Type:	**Warranty Deed**	Owner Name:	**Aberly Scott T**
Owner Name 2:	**Aberly Sylvia**	Seller Name:	**Newcomm Robert S & Fern P**

History

Listing History from MLS

ListingID: 4039929 Sts: Active
Parcel #: 201822

1603 Harlan Street, Lakewood, CO 80214
Residential Income, Triplex

LA: James Stewart
LO: Coldwell Banker Res Brokerage

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
05/29/2020	Back On Market	PND->ACT	05/29/20 - 10:20 AM	3
04/04/2020	Pending	ACT->PND	04/05/20 - 07:10 AM	3
04/02/2020	New Listing	ACT-> $525,000	04/02/20 - 01:54 PM	

Sale History from Public Records

Sale Date	*Sale Price*	*Nom*	*Buyer Name(s)*	*Seller Name(s)*	*Doc. #*	*Document Type*	*Title Company*	Multi/Split *Sale*
07/31/96	$124,950		Aberly Scott T & Sylvia Aberly Sylvia	Newcomm Robert S & Fern P	F0279141	Warranty Deed		

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	*Mrtg Type* Code	Term	Int Rate	*Int Rate* Type	Borrower Name(s):	Title Company
10/20/04	$86,000			YEARS	1	7	FIXED RATE LOAN	Aberly Sylvia Aberly Scott T	Land Title Guarantee
10/20/04	$353,000	Cit Small Busn Lending Corp	SMALL BUSINESS ADMINISTRATION	YEARS	25		FIXED RATE LOAN	Aberly Scott T Aberly Sylvia	Land Title Guarantee
07/25/03	$159,300	Universal Lending	CONVENTIONAL	YEARS	30		FIXED RATE LOAN	Aberly Scott T Aberly Sylvia	Lawyers Title
03/12/01	$157,500	Universal Lending	CONVENTIONAL	YEARS	30			Aberly Scott T Aberly Sylvia	Title Services Inc.
08/02/96	$105,000	Loan America Fin'l Corp	CONVENTIONAL					Aberly Scott T Aberly Sylvia	

5344 S Lakeview Street, Littleton, CO 80120 — $599,000 - Pending

Listing

Listing ID:	**5604937**	MLS Status:	Pending
		Accepting Backups:	**Yes**
List Price:	**$599,000**	Original List Price:	**$625,000**
Property Type:	**Residential Income/Triplex**		
Levels:	**One**	Basement:	**Yes**
County:	**Arapahoe**	Year Built:	**1961**
Subdivision Name:	**Bruss Subdivison**		
Listing Contract Date:	**05/08/2020**	Spec. Listing Cond:	**None Known**
Purchase Contract Date:	**05/27/2020**	Contingency:	**None Known**
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Annl:	**$0**
Tax Annual Amt:	**$2,678**	Tax Year:	**2019**
Tax Legal Desc:	**LOT 3 BLK 2 BRUSS SUB**		

Recent: 05/27/2020 : PEND : A->P

Interior Area & SqFt

Building Area Total (SqFt Total):	**2,640**	Living Area (SqFt Finished):	**2,640**	Area Source:	**Public Records**
Above Grade Finished Area:	**2,640**				
Below Grade Total Area:	**0**	Below Grade Finished Area:	**0**	Below Grade Unfinished Area:	**0**
PSF Total:	**$227**	PSF Above Grade:	**$227**	PSF Finished:	**$227**

Basement:	**Partial, Unfinished**	Bsmnt Ceiling Ht:	**8 feet**
Foundation Details:	**Concrete Perimeter, Slab**		
Heating:	**Forced Air, Natural Gas**	# FP, FP Features	**0**
Cooling:	**None**		
Interior Features:	**Eat-in Kitchen**		
Security Features:	**Carbon Monoxide Detector(s), Smoke Detector(s)**	Flooring:	**Carpet, Vinyl**
Appliances:	**Dishwasher, Gas Water Heater, Refrigerator**		
Other Equipment:		Laundry:	**In Unit, Main Level**
Exclusions:	**Refrigerator in Unit 5346 and other personal property belonging to tenants.**		

Financials & Expenses

Cap Rate:	**5.00**	Cap Rate Calculation:	**NOI/List price**
Actual		Projected	
Gross Income:	**43,320.00**	Gross Income:	
Operating Expense:	**11,732.00**	Annual Expense:	
Annual Net Income:	**31,588.00**	Annual Net Income:	

Operating Expense Includes: **Accounting, Insurance, Maintenance, Professional Management, Real Estate Tax, Utilities**

Owner Pays:	**Exterior Maintenance, Grounds Care**	Utility Billing To Tenants:	**Direct Billing from Utility**
Tenant Pays:	**Cable TV, Electricity, Gas, Internet, Trash Collection**	Utility Metering:	**Separate Electric, Separate Gas**

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
2 Bedroom	**3**	**$1,203**	**820**	**1**	**2**	**1**	**1**	**0**	**0**	**1**	**2**	**3**	**0**		**1**	**1 unit @ $1,150 + 2 units @$1,230**

Parking

Parking Total:	**4**	Garage Spaces:	**0**	Offstreet Spaces:	**4**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	**4**			

Parking Features: **Concrete**

Site & Location Information

Lot Size:	**0.24 Acres / 10,280 SqFt**	Fencing:	**Partial**
Lot Features:	**Irrigated, Level, Sprinklers In Front, Sprinklers In Rear**		
Road Responsibility:	**Public Maintained Road**		
		Elementary School:	**Field / Littleton 6**
Bldg/Complex Name:		Middle/Junior Sch:	**Goddard / Littleton 6**
		High School:	**Littleton / Littleton 6**
Parcel Number:	**032036192**	School of Choice:	
Is Incorporated:	**Yes**	Zoning:	**R-4**
Walk Score:	**61**	View Walk, Bike, & Transit Scores	
Distance To Bus:	**500 Feet**	Distance To Light Rail:	

Building Information

Architectural Style:	**Traditional**		
Entry Level/Loc:	**1/Exterior Access**	Common Walls:	**End Unit, 1 Common Wall, 2+ Common Walls**
Direction Faces:	**West**	View:	

Construction Materials: **Brick**
Roof: **Composition**
Patio/Porch Feat: **Patio**
Exterior Features: **Private Yard, Rain Gutters**
Pool Features:

Water & Utilities

Water Source: **Public**
Utilities: **Cable Available, Electricity Connected, Natural Gas Connected, Phone Available**
Sewer: **Public Sewer**
Electric: **110V, 220 Volts**

Public Remarks

Estate sale. Rare find in Littleton! Great location! Great condition! Great opportunity! Brick side-by-side Triplex. Individually metered. Stable property with long term tenants who have taken very good care of the property. All three units show well! Exterior access to common area basement where each unit has a secured storage room. See pics and 3-D Interactive Tours of the whole property! TAKE NOTE! Virtual Tour 1 is of unit #5344, Virtual Tour 2 is of unit #5346, and Virtual Tour 3 is of unit #5348. Pics are labeled and in order beginning with exterior photo of unit #5344. Keep scrolling down to view the rest of the units. BETWEEN the TOURS and PICS you will see everything, inside and out. If you have a problem with opening or viewing the tours in your browser, use Internet Explorer. Please feel free to call or email me with questions or more details. Better Hurry! This one won't last!

Directions

Broadway to west on Littleton Blvd to Delaware Street. Turn right or go north on Delaware Street to Crestline Avenue and turn left of go west to Lakeview Street then turn right or go north on Lakeview to property , on the right or east side of street.

Confidential Information

Private Remarks: **Estate sale, even though it's in the names of the heirs. Use a special warranty deed to convey title. Not much cash left in the estate for repairs and improvements. Will be sold as-is. Due to the property being tenant occupied and coronavirus showing restrictions, the property must be shown virtually without an accepted contract, no exceptions. The tours and pics are thorough and show almost everything. The units are always that clean and neat too! Feel free to call with questions or to discuss.**

Buyer Agency Comp: **2.8%**
Transaction Broker Comp: **2.8%**
Contract Earnest Check To: **Land Title Guarantee Company**
Contract Min Earnest: **$8,000**
Title Company: **Land Title Guarantee Company**
Investor Blackout End Date:
Dual Variable: **No**
Listing Terms: **Cash, Conventional**
Docs Available:
Submitted Prosp: **No**
Possession: **Closing/DOD, Other, Rental Agreement**
Ownership: **Estate**
Home Warranty: **No**

Showing Information

Showing Contact Phone: **303-888-6489**
Showing Instructions: ***Please note: Due to the property being tenant occupied and coronavirus showing restrictions please see Public Remarks, Pics, and 3-D virtual tours. No showings without an accepted contract. Feel free to drive by the property, but please do not bother tenants. Call listing broker with questions.***
Occupant Type: **Tenant**
Show Email:
No Showings Until:

List Agent

List Agent: Michael Dovel
List Agent ID: **229911**
Phone: **303-888-6489**
Mobile: **303-888-6489**
Office: **303-771-9400**
Email: mike@coloradorelocate.com
List Office: RE/MAX Masters Millennium
List Office ID: **rem36**

Generated on:
06/05/2020 9:23:03 AM

Tax

Characteristics

Lot Frontage:	**75**	Lot Depth:	**135**
Lot Acres:	**0.236**	Lot Sq Ft:	**10,280**
Land Use - County:	**Duplex/Triplex**	Land Use - CoreLogic:	**Duplex**
Building Type:	**Three Family**	Style:	**RANCH**
Year Built:	**1961**	Bldg Sq Ft - Above Ground:	**2,640**
Bldg Sq Ft - Basement:	**858**	Bldg Sq Ft - Finished:	**2,640**
Bldg Sq Ft - 1st Floor:	**2,640**	Basement Type:	**Basement**
# Buildings:	**1**	Bedrooms:	**6**
Baths - Total:	**3**	Baths - Full:	**3.000**
Stories:	**1.0**	Heat Fuel Type:	**GAS**
Heat Type:	**Forced Air**	Patio Type:	**Patio/Terrace**

Garage Capacity:	**0**	Roof Material:	**Asphalt Shingle**
Exterior:	**Brick Veneer**	Foundation:	**Concrete**
Quality:	**AVERAGE**	Equipment:	**DISHWASHER, DISPOSAL**

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Basement Total	**S**	**858**			
Patio Slab Or Terrace	**S**	**374**			
First Floor	**S**	**2,640**			

Owner Information

Owner Name:	**Sinha Alok**	Owner Name 2:	**Odell-Sinha Nakisa**
Mailing Address:	**3301 Coors Boulevard NW R- #308**	Mailing City & State:	**Albuquerque Nm**
		Mailing Zip:	**87120**
Owner Occupied:	**No**		

Location Information

Property Zip:	**80120**	Property Zip4:	**1508**
Property Carrier Route:	**C014**	School District:	**Littleton 6**
Elementary School:	**FIELD**	Middle School:	**GODDARD**
High School:	**LITTLETON**	Subdivision:	**Bruss Sub**
Census Tract:	**006601**	Topography:	**FLAT/LEVEL**
Neighborhood Code:	**3032**	Township Range and Section:	**5S6815**
Quarter:	**NW**	Block:	**2**
Lot:	**3**		

Tax Information

PIN:	**2077-15-2-07-003**	Alternate PIN:	**032036192**
Schedule Number:	**207715207003**	% Improved:	**51**
Tax District:	**0910**		
Legal Description:	**LOT 3 BLK 2 BRUSS SUB**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$196,350**	**$116,875**	**$116,875**
Market Value - Improved	**$208,250**	**$305,125**	**$305,125**
Market Value - Total	**$404,600**	**$422,000**	**$422,000**
Assessed Value - Land	**$14,039**	**$8,415**	**$8,415**
Assessed Value - Improved	**$14,890**	**$21,969**	**$21,969**
Assessed Value - Total	**$28,929**	**$30,384**	**$30,384**
YOY Assessed Change ($)	**-$1,455**	**$**	
YOY Assessed Change (%)	**-5%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$2,677.77**	**$2,646.20**	**$2,451.91**
Change ($)	**$32**	**$194**	
Change (%)	**1%**	**8%**	

Last Market Sale

Sale Date:	**09/29/2004**	Price per SqFt - Finished:	**$121.78**
Deed Type:	**Personal Representative's Deed**	Owner Name:	**Sinha Alok**
		Owner Name 2:	**Odell-Sinha Nakisa**
Seller Name:	***Skinner Clifford R***		

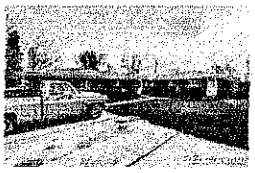
History

Listing History from MLS

ListingID: 5604937 Sts: Pending
Parcel #: 032036192

5344 S Lakeview Street, Littleton, CO 80120
Residential Income, Triplex

LA: Michael Dovel
LO: Re/Max Masters Millennium

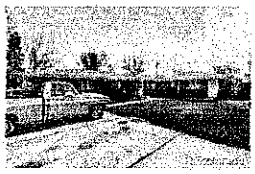


Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
05/27/2020	Pending	ACT->PND	05/27/20 - 10:53 AM	4
05/25/2020	Price Decrease	$625,000->$599,000	05/25/20 - 09:01 AM	2
05/25/2020	Back On Market	PND->ACT	05/25/20 - 08:40 AM	2
05/10/2020	Pending	ACT->PND	05/10/20 - 08:32 PM	2
05/08/2020	New Listing	ACT-> $625,000	05/08/20 - 09:48 AM	

ListingID: 8358902 Sts: Expired
Parcel #: 032036192

5344 S Lakeview Street, Littleton, CO 80120
Residential Income, Quadplex

LA: Michael Dovel
LO: Re/Max Masters Millennium



Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
05/08/2020	Expired	ACT->EXP	05/08/20 - 09:27 AM	1
05/07/2020	New Listing	ACT-> $625,000	05/07/20 - 10:34 PM	

Sale History from Public Records

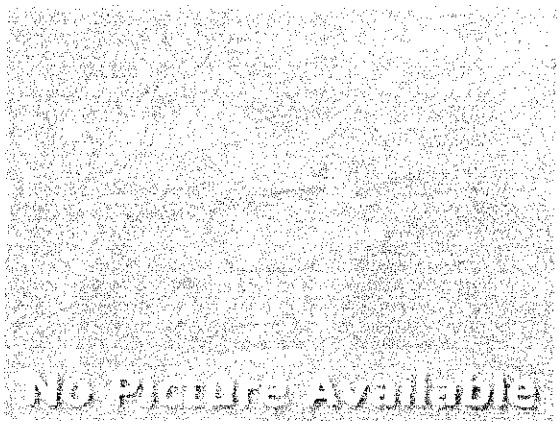
Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
11/18/19		Y	Sinha Alok Odeli-Sinha Nakisa	Sinha Nancy J	D9126696	Personal Representative's Deed	Attorney Only	
09/29/04	$321,500		Sinha Ashwini K & Nancy J Sinha Nancy J	Skinner Clifford R	B4173140	Personal Representative's Deed	First American Title	

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate	Int Rate Type	Borrower Name(s):	Title Company
10/01/04	$221,130	* Other Institutional Lenders	CONVENTIONAL	YEARS	30		FIXED RATE LOAN	Sinha Ashwini K Sinha Nancy J	

2270 Billings Street, Aurora, CO 80011 — $575,000 - Pending

Listing



Listing ID:	**5188824**	MLS Status:	Pending
		Accepting Backups:	**Yes**
List Price:	**$575,000**	Original List Price:	**$575,000**
Property Type:	**Residential Income/Triplex**		
Levels:	**Three Or More**	Basement:	**Yes**
County:	**Adams**	Year Built:	**1974**
Subdivision Name:	**Northwestern Aurora**		
Listing Contract Date:	**05/26/2020**	Spec. Listing Cond:	**None Known**
Purchase Contract Date:	**05/27/2020**	Contingency:	**None Known**
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Annl:	**$0**
Tax Annual Amt:	**$3,544**	Tax Year:	**2019**
Tax Legal Desc:	**SUB:SABLE VILLAGE FILING NO 1 BLK:2 LOT:2**		

Recent: 05/27/2020 : PEND : A->P

Interior Area & SqFt

Building Area Total (SqFt Total):	**4,851**	Living Area (SqFt Finished):	**4,851**	Area Source:	**Public Records**
Above Grade Finished Area:	**3,234**				
Below Grade Total Area:	**1,617**	Below Grade Finished Area:	**1,617**	Below Grade Unfinished Area:	**0**
PSF Total:	**$119**	PSF Above Grade:	**$178**	PSF Finished:	**$119**

Basement: **Partial**
Bsmnt Ceiling Ht:
Foundation Details: **Concrete Perimeter**
Heating: **Forced Air**
FP, FP Features
Cooling: **None**
Exclusions: **Tenant personal property.**

Financials & Expenses

Cap Rate: **7.00**
Cap Rate Calculation: **See complete pro forma attached in supplements.**

Actual | Projected

Unit Information

Unit Type	#Units	Avg Rent	SqFt	Prk Sp	Beds	Bath	DishWsh	Wshr	Dryer	Hkup	Fridge	Stove	AC	Firepl	Storage	Unit Desc
4 Bedroom Or More	**3**	**$1,366**	**4,851**	**16**	**12**	**7**	**3**			**3**	**3**	**3**				**6 of the 12 beds are non conforming in the basement.**

Parking

Parking Total: **10** Garage Spaces: **0** Offstreet Spaces: **10**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Off-Street	**10**			

Site & Location Information

Lot Size: **0.36 Acres / 15,500 SqFt**
Fencing:
Elementary School: **Sable / Adams-Arapahoe 28J**
Bldg/Complex Name:
Middle/Junior Sch: **North /**
High School: **Hinkley / Adams-Arapahoe 28J**
Parcel Number: **R0085385**
School of Choice:
Walk Score: **20**
View Walk, Bike, & Transit Scores

Building Information

Architectural Style:
Entry Level/Loc: **1/Ground**
Common Walls: **1 Common Wall**
Construction Materials: **Frame**
Roof: **Composition**
Exterior Features:
Patio/Porch Feat: **Covered, Front Porch**
Pool Features:

Water & Utilities

Water Source: **Public**
Sewer: **Public Sewer**

Outbuildings

of Outbuildings: **1**

Outbuilding Type	SqFt	Stories	Yr Blt	Stalls	Doors	Length/Width	Floor	Stall Floor	Features	Description
Shed(s)	**120**	**1**								

Public Remarks

Great cash flow in a developing area of Aurora. Professional property manager assessed market rents at $5100/month.

***Current rent is $4100/month. A real 7% cap rate with no funny math. Full Pro Forma available upon request. Walk to University/VA hospital and Lightrail. Convenient to retail and I-225. Brand new roof, siding and windows.**

Confidential Information

Private Remarks: **Accepting back up offers. Call listing agent Jim Doolittle at (303) 913-2333 for showings.**

Buyer Agency Comp:	**2.8%**	Dual Variable:	**No**	Submitted Prosp:	**No**
Transaction Broker Comp:	**2.8%**				
Contract Earnest Check To:	**First American Title**			Possession:	
Contract Min Earnest:		Listing Terms:	**1031 Exchange, Cash, Conventional**		
Title Company:	**First American Title**			Ownership:	**Individual**

Showing Information

Showing Contact Phone:		Show Email: jim.doolittle@realatlas.com	No Showings Until:
Showing Instructions:	**Text Jim Doolittle (303) 913-2333**		
Occupant Type:	**Tenant**		

List Agent

List Agent:	James Doolittle	Phone:	**303-913-2333**
List Agent ID:	**55051181**	Mobile:	**303-913-2333**
		Office:	**303-242-8980**
List Office:	Atlas Real Estate Group	Email:	JIM.DOOLITTLE@REALATLAS.COM

List Office ID: **AREG1**

Generated on:
06/05/2020 9:23:06 AM

Tax

Characteristics

Lot Frontage:	**124**	Lot Depth:	**125**
Lot Acres:	**0.356**	Lot Sq Ft:	**15,500**
Land Use - County:	**Duplex/Triplex**	Land Use - CoreLogic:	**Duplex**
Building Type:	**Triplex**	Style:	**TRIPLEX**
Year Built:	**1974**	Bldg Sq Ft - Above Ground:	**3,234**
Bldg Sq Ft - Basement:	**1,617**	Bldg Sq Ft - Total:	**4,851**
Bldg Sq Ft - Finished:	**3,234**	Bldg Sq Ft - 1st Floor:	**1,617**
Bldg Sq Ft - 2nd Floor:	**1,617**	Basement Type:	**Unfinished**
# Buildings:	**1**	Total Rooms:	**12.000**
Bedrooms:	**6**	Baths - Total:	**6**
Baths - Full:	**6.000**	Stories:	**1.0**
Cooling Type:	**Central**	Heat Type:	**Forced Air**
Garage Capacity:	**0**	Roof Material:	**Composition Shingle**
Construction:	**Frame**	Exterior:	**Frame**
Quality:	**FAIR**	Equipment:	**WHE, SSK**

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Bath 4	**U**	**3**			
Wood Roof	**S**	**196**			
Water Heater	**U**	**3**			
Unfinished	**S**	**1,617**			
Laundry Facility	**U**	**3**			
Rough In	**U**	**3**			
Sink Standard	**U**	**3**			
First Floor	**S**	**1,617**			
Second Floor	**S**	**1,617**			
Allowance	**U**	**3**			

Building Description	Building Size
DUPLEX	**1**

Owner Information

Owner Name:	**Mendez Mario A**	Mailing Address:	**17155 W 12th Ave**
Mailing City & State:	**Golden Co**	Mailing Zip:	**80401**
Mailing ZIP 4:	**2813**	Mailing Carrier Route:	**C007**
Owner Occupied:	**No**		

Location Information

Property Zip:	**80011**	Property Zip4:	**4245**
Property Carrier Route:	**C094**	School District:	**Adams-Arapahoe 28J**
Elementary School:	**SABLE**	Middle School:	**NORTH**
High School:	**HINKLEY**	Subdivision:	**Sable Village Filing 1**
Census Tract:	**008308**	Neighborhood Code:	**620**
Onboard Neighborhood Description:	**SABLE PLACE CONDOMINIUMS**	Township Range and Section:	**3S6631**
Quarter:	**NE**	Block:	**2**
Lot:	**2**		

Tax Information

PIN:	**R0085385**	Alternate PIN:	**1821-31-2-16-001**
Schedule Number:	**R0085385**	% Improved:	**76**
Tax District:	**360**		
Legal Description:	**SUB:SABLE VILLAGE FILING NO 1 BLK:2 LOT:2**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$101,000**	**$60,000**	**$60,000**
Market Value - Improved	**$319,890**	**$269,641**	**$269,641**
Market Value - Total	**$420,890**	**$329,641**	**$329,641**
Assessed Value - Land	**$7,220**	**$4,320**	**$4,320**
Assessed Value - Improved	**$22,870**	**$19,410**	**$19,410**
Assessed Value - Total	**$30,090**	**$23,730**	**$23,730**
YOY Assessed Change ($)	**$6,360**	**$**	
YOY Assessed Change (%)	**27%**	**0%**	
Tax Year	**2019**	**2018**	**2017**
Total Tax	**$3,544.42**	**$2,807.34**	**$2,493.96**
Change ($)	**$737**	**$313**	
Change (%)	**26%**	**13%**	

Last Market Sale

Sale Date:	**07/23/2010**	Price per SqFt - Finished:	**$49.47**
Document Number:	**0000C1093468**	Deed Type:	**Special Warranty Deed**
Owner Name:	**Mendez Mario A**	Seller Name:	**Us Capital Funding Llc**

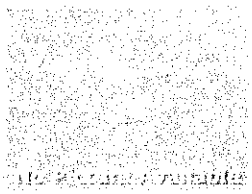
History

Listing History from MLS

ListingID: 5188824 Sts: Pending
Parcel #: R0085385

2270 Billings Street, Aurora, CO 80011
Residential Income, Triplex

LA: James Doolittle
LO: Atlas Real Estate Group



Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
05/27/2020	Pending	ACT->PND	05/27/20 - 08:54 AM	1
05/26/2020	New Listing	ACT-> $575,000	05/26/20 - 05:15 PM	

ListingID: 3999780 Sts: Expired
Parcel #: R0085385

2270 N Billings Street, Aurora, CO 80011
Residential Income, Triplex

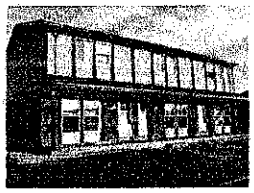
LA: Jennifer Verhey
LO: Happy Homes Real Estate

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
05/18/2020	Expired	WTH->EXP	05/18/20 - 02:41 PM	1
04/07/2020	Withdrawn	ACT->WTH	04/07/20 - 12:57 PM	1
04/06/2020	New Listing	ACT-> $650,000	04/06/20 - 09:45 PM	

ListingID: 843193 Sts: Closed
Parcel #:

2270 Billings Street, Aurora, CO 80011
Residential Income, Triplex

LA: Stacy A. Nolan
LO: Integrity Transitions Re Llc

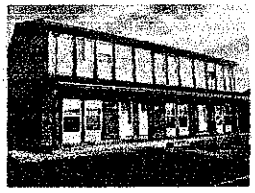


Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
07/25/2010	Closed	($160,000)	07/25/10 - 12:21 PM	
04/30/2010	Pending	ACT->PND	04/30/10 - 07:43 PM	
01/19/2010	New Listing	ACT-> $199,900	01/19/10 - 07:55 PM	

ListingID: 746081 Sts: Withdrawn
Parcel #:

2270 Billings Street, Aurora, CO 80011
Residential Income, Triplex

LA: Jeffrey Meythaler
LO: Integrity Transitions Re Llc



Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
01/19/2010	Withdrawn	ACT->WTH	01/19/10 - 07:55 PM	
01/19/2010	*Back On Market*	*PND->ACT*	*01/19/10 - 07:53 PM*	
11/08/2009	Pending	ACT->PND	11/08/09 - 09:03 PM	
09/21/2009	Price Decrease	$179,900->$169,900	09/21/09 - 10:29 AM	
08/07/2009	Back On Market	PND->ACT	08/07/09 - 12:40 PM	
08/03/2009	Pending	ACT->PND	08/03/09 - 02:14 PM	
06/29/2009	Back On Market	PND->ACT	06/29/09 - 03:21 PM	
05/14/2009	Pending	ACT->PND	05/14/09 - 04:35 PM	
03/11/2009	Price Decrease	$199,900->$179,900	03/11/09 - 09:16 AM	
02/23/2009	New Listing	ACT-> $199,900	02/23/09 - 12:01 PM	

Sale History from Public Records

Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
08/08/16		Y	Mendez Mario A	Mendez Lisa A	66921	Quit Claim Deed	Heritage Title Co.	
06/29/16		Y	Mendez Mario A	Mendez Lisa	52516	Quit Claim Deed		
03/16/12		Y	Mendez Lisa A & Mario A Mendez Mario A	Mendez Lisa A	24321	Joint Tenant Quit Claim Deed		
07/23/10	$160,000		Cantin Lisa A	Us Capital Funding Llc	50710	Special Warranty Deed	United Title/Co	
03/06/09		Y	Us Capital Funding Llc	Public Trustee Of Adams County	16176	Public Trustees Deed		
09/28/06		Y	Medina Josefina	Medina Josefina	988354	Quit Claim Deed	Metro Denver Title	
12/15/05		Y	Medina-Fletes Hector F	Medina Hector F	1377630	Quit Claim Deed		
12/15/05		Y	Medina-Fletes Hector Medina Josefina	Medina Hector F	1377530	Quit Claim Deed		

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate	Int Rate Type	Borrower Name(s):	Title Company
08/15/16	$158,000	Us Bk National Assn	CONVENTIONAL	YEARS	30			Mendez Mario A	
06/05/12	$157,500	Megastar Fin'l Corp	CONVENTIONAL	YEARS	30			Mendez Lisa A Mendez Mario A	Guardian Title Agency The
07/30/10	$120,000	Megastar Fin'l Corp	CONVENTIONAL	YEARS	30			Cantin Lisa A	
10/10/06	$290,400	Peoples Choice	CONVENTIONAL	YEARS	30		ADJUSTABLE LOAN	Medina Josefina	
10/25/01	$238,400	First Nat'l Bk/Az	CONVENTIONAL	YEARS	30			Medina Hector F	
12/24/92	$59,500	Countrywide Fndg	CONVENTIONAL					Lewis Marie T	
09/06/90	$12,000		PRIVATE PARTY LENDER					Inc	

4000 Jay Street, Wheat Ridge, CO 80033 — $642,500 - Closed

Listing

Listing ID:	**2338078**	MLS Status:	**Closed**
List Price:	**$640,000**	Original List Price:	**$640,000**
Property Type:	**Residential Income/Triplex**		
Levels:	**Two**	Basement:	**Yes**
County:	**Jefferson**	Year Built:	**1960**
Subdivision Name:	**Wheat Ridge**		
Listing Contract Date:	**10/21/2019**	Spec. Listing Cond:	**None Known**
Purchase Contract Date:	**12/04/2019**	Contingency:	**None Known**
Close Date:	**03/06/2020**	Close Price:	**$642,500**
Days in MLS:	**44**		
Association: **N** Multiple:	Cov/Rest: **N**	Assoc Fee Tot Anni:	**$0**
Tax Annual Amt:	**$2,447**	Tax Year:	**2019**
Tax Legal Desc:	**857800 WRIGHT**		

Interior Area & SqFt

Building Area Total (SqFt Total):	**2,989**	Living Area (SqFt Finished):	**2,989**	Area Source:	
Above Grade Finished Area:	**1,789**				
Below Grade Total Area:	**1,200**	Below Grade Finished Area:	**1,200**	Below Grade Unfinished Area:	**0**
PSF Total:	**$215**	PSF Above Grade:	**$359**	PSF Finished:	**$215**

Basement: **Finished, Full** Bsmnt Ceiling Ht:
Heating: **Forced Air, Natural Gas** # FP, FP Features
Cooling: **None**
Exclusions: **Seller's Personal Property not used in operation of Property.**

Financials & Expenses

Actual		Projected	
Gross Income:	**54,885.00**	Gross Income:	**60,695.00**
Operating Expense:	**16,980.00**	Annual Expense:	**16,084.00**
Annual Net Income:	**37,905.00**	Annual Net Income:	**44,611.00**
Owner Pays:		Utility Billing To Tenants:	**Direct Billing from Utility**
Tenant Pays:	**Electricity, Gas, Internet, Trash Collection, Water**	Utility Metering:	**Separate Electric, Separate Gas**

Parking

Parking Total: **5** Garage Spaces: **5** Offstreet Spaces: **0**

Parking Type	# of Spaces	Parking Length	Parking Width	Parking Description
Garage (Detached)	**5**			

Parking Features: **Garage**

Site & Location Information

Lot Size: **0.35 Acres / 12,200 SqFt**
Bldg/Complex Name:
Parcel Number: **300025631**
Is Incorporated:
Walk Score: **59**

Fencing: **Full**
Elementary School: **Stevens / Jefferson County R-1**
Middle/Junior Sch: **Everitt / Jefferson County R-1**
High School: **Wheat Ridge / Jefferson County R-1**
School of Choice:
Zoning: **R3**
View Walk, Bike, & Transit Scores

Building Information

Architectural Style:
Entry Level/Loc: **Exterior Access**
Construction Materials: **Brick**
Roof: **Architectural Shingles**
Patio/Porch Feat: **Deck, Front Porch**
Common Walls:
Exterior Features: **Balcony**
Pool Features:

Public Remarks

Fully stabilized 3-plex, on a large lot. Each unit has private entrance/exit. 5 total garage spots. 3 spots included in leases to units 4000 & 4002 Jay St. 2 detached garage spots independently leased by Management.

Confidential Information

Buyer Agency Comp: **2.25%**
Contract Earnest Check To: **Brianna Corwin**
Contract Min Earnest: **$50,000**
Title Company: **Stewart Title**
Dual Variable: **No**
Listing Terms: **Cash, Conventional**
Submitted Prosp: **No**
Possession:
Ownership: **Corporation/Trust**

List Agent

List Agent: Justin Brockman
List Agent ID: 55047737
Phone: 303-993-9803
Mobile: 303-993-9803
Office: 303-993-9803
List Office: Brockman Group LLC
Email: management@brockman.group
List Office ID: M7499

Buyer Agent

Buyer Agent: Thomas Graeve
Buyer Office: Pinnacle Real Estate Advisors
Phone: 303-962-9539
Email: tgraeve@pinnaclerea.com
Buyer Agent ID: 038734
Buyer Office ID: M0485

Close Information

Concessions: No
Commission Modified: NA
Buyer Financing: Conventional
Closing Comments:

Generated on:
06/05/2020 9:23:12 AM

Tax

Characteristics

Lot Acres:	0.280	Lot Sq Ft:	12,200
Land Use - CoreLogic:	Sfr	Building Type:	Duplex
Style:	RANCH	Year Built:	1960
Bldg Sq Ft - Above Ground:	1,729	Bldg Sq Ft - Basement:	1,260
Bldg Sq Ft - Finished Basement:	1,260	Bldg Sq Ft - Total:	469
		Bldg Sq Ft - Finished:	1,729
Bldg Sq Ft - 1st Floor:	1,260	Basement Type:	Finished
# Buildings:	2	Bedrooms:	6
Baths - Total:	4	Baths - Full:	4.000
Stories:	1.0	Fireplace:	Y
Fireplaces:	2	Heat Type:	Forced Air
Patio Type:	Wood Deck	Garage Type:	Detached Garage
Garage Capacity:	0	Garage Sq Ft:	900
Construction:	Masonry	Water:	TYPE UNKNOWN
Sewer:	Type Unknown	Quality:	AVERAGE

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Shed	S	64			1984
Residential Use	S	900			
Detached Garage	S	84			
Covered Porch	S	64			
Outbuilding/Extra Features	S	1,260			
First Floor	S	1,260			
Basement Total	S	270			
Wood Deck					

Building Features

Feature Type	Unit	Size/Qty	Width	Depth	Year Blt
Enclosed Porch	S	129			
Attached Garage	S	1,041			
First Floor	S	469			

Owner Information

Owner Name:	Kr Investment Group Llc	Mailing Address:	1735 N Ogden St #301
Mailing City & State:	Denver Co	Mailing Zip:	80218
Mailing ZIP 4:	1076	Mailing Carrier Route:	C041
Owner Occupied:	No		

Location Information

Property Zip:	**80033**	Property Zip4:	**5019**
Property Carrier Route:	**C002**	School District:	**Jefferson County R-1**
Elementary School:	**STEVENS**	Middle School:	**EVERITT**
High School:	**WHEAT RIDGE**	Subdivision:	**Wright**
Census Tract:	**010603**	Neighborhood Code:	**2405**
Onboard Neighborhood Description:	**HALE**	Township Range and Section:	**036924**
Quarter:	**SW**	Lot:	**3**

Tax Information

PIN:	**025631**	Alternate PIN:	**39-243-18-001**
Schedule Number:	**025631**	% Improved:	**61**
Tax District:	**3139**		
Legal Description:	**SECTION 24 TOWNSHIP 03 RANGE 69 SUBDIVISIONCD 857800 SUBDIVISIONNAME WRIGHT BLOCK LOT 0003 SIZE: 12200 TRACT VALUE: .280**		

Assessment & Taxes

Assessment Year	2019	2018	2017
Market Value - Land	**$226,696**	**$143,963**	**$143,963**
Market Value - Improved	**$351,959**	**$237,516**	**$237,516**
Market Value - Total	**$578,655**	**$381,479**	**$381,479**
Assessed Value - Land	**$16,209**	**$10,365**	**$10,365**
Assessed Value - Improved	**$25,165**	**$17,101**	**$17,101**
Assessed Value - Total	**$41,374**	**$27,466**	**$27,466**
YOY Assessed Change ($)	**$13,908**	**$**	
YOY Assessed Change (%)	**51%**	**0%**	

Tax Year	2019	2018	2017
Total Tax	**$3,563.42**	**$2,447.44**	**$2,210.04**
Change ($)	**$1,116**	**$237**	
Change (%)	**46%**	**11%**	

Last Market Sale

Sale Date:	**03/06/2020**	Price per SqFt - Finished:	**$371.60**
Deed Type:	**Special Warranty Deed**	Owner Name:	**Kr Investment Group Llc**
Seller Name:	**Foothills Property Group Llc**		

History

Listing History from MLS

ListingID: 2338078 Sts: Closed
Parcel #: 300025631

4000 Jay Street, Wheat Ridge, CO 80033
Residential Income, Triplex

LA: Justin Brockman
LO: Brockman Group Llc

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
03/06/2020	Closed	($642,500)	03/06/20 - 02:58 PM	44
12/04/2019	Pending	ACT->PND	12/04/19 - 11:43 AM	44
10/21/2019	New Listing	ACT-> $640,000	10/21/19 - 06:35 PM	

ListingID: 784965 Sts: Closed
Parcel #:

4000 Jay Street, Wheat Ridge, CO 80033
Residential Income, Duplex

LA: Scott Kilpatrick
LO: Re/Max Alliance-Evergreen

Effective Date	Change Type	Prev -> New	Change Timestamp	Days in MLS
11/02/2009	Closed	($175,000)	11/02/09 - 12:47 PM	
08/30/2009	Pending	ACT->PND	08/30/09 - 10:36 AM	
08/24/2009	Back On Market	PND->ACT	08/24/09 - 04:49 PM	
07/03/2009	Pending	ACT->PND	07/03/09 - 02:27 PM	
06/23/2009	New Listing	ACT-> $190,000	06/23/09 - 02:48 PM	

Sale History from Public Records

Sale Date	Sale Price	Nom	Buyer Name(s)	Seller Name(s)	Doc. #	Document Type	Title Company	Multi/Split Sale
03/06/20	$642,500		Kr Investment Group Llc	Foothills Property Group Llc	28015	Special Warranty Deed	Stewart Title	
09/08/09	*$175,000*		*Foothills Property Group Llc*	*Us Bank Na Bafc 2007-4*	*109864*	*Special Warranty Deed*	*Colorado Escrow & Title Svcs*	
05/01/09		Y	Us Bank Na Bafc 2007-4	Chief Deputy Public Te Of Jeffers	38832	Public Trustees Deed		
09/29/94	$179,900		Gray Steven E	Stewart Max E	94159023	Warranty Deed		
12/27/91	$113,000		Stewart Max E	Schlicher Stephen A	91121817	Warranty Deed		
03/26/87		Y	Schlicher Stephen A	Schlicher Colleen A	87040455	Quit Claim Deed		

Mortgage History

Date	Amount	Mortgage Lender	Mortgage Type	Mrtg Type Code	Term	Int Rate	Int Rate Type	Borrower Name(s):	Title Company
03/11/20	$514,000	Firstbank	CONVENTIONAL	YEARS	30	4	ADJUSTABLE *INT RATE* LOAN	Kr Investment Group *Llc*	
11/03/09	$186,700	Firstbank/Wheat Ridge	CONVENTIONAL	YEARS	30	5.125	ADJUSTABLE INT RATE LOAN	Foothills Property Group Llc	
03/02/07	$103,500	American Brokers Conduit	CONVENTIONAL	YEARS	15			Gray Steven E	
03/02/07	$241,500	American Brokers Conduit	CONVENTIONAL	YEARS	30			Gray Steven E	
03/04/04	$75,000	Citywide Banks	CONVENTIONAL				ADJUSTABLE INT RATE LOAN	Gray Steven E	
11/18/02	$175,108	Commercial Fed Bk	CONVENTIONAL	YEARS	10		FIXED RATE LOAN	Gray Steven E	
06/28/02	$70,000	Wells Fargo Bk West Na	CONVENTIONAL	YEARS	30		FIXED RATE LOAN	Gray Steven E	

Foreclosure History

CERTIFICATE OF PURCHASE

Document Type: **CERTIFICATE OF PURCHASE**
Default Date:
Foreclosure Filing Dt:
Recording Date: **04/10/2009**
Document Number: **31514**
Book Number:
Page Number:
Default Amount:
Final Judgement Amt:
Orlginal Doc Date: **03/02/2007**
Original Document #: **24172**
Original Book/Page:
Lien Type:

Document Type: **NOTICE OF TRUSTEE'S SALE**
Default Date:
Foreclosure Filing Dt: **11/20/2008**
Recording Date: **12/02/2008**
Document Number: **108955**
Book Number:
Page Number:
Default Amount:
Final Judgement Amt: **$238,770**
Original Doc Date: **03/02/2007**
Original Document #: **24172**
Original Book/Page:
Lien Type:

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

BOARD OF COUNTY COMMISSIONERS

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0077814/15 Parcel N0.(S) 0172131205001/002

2. The subject property is classified as a Commercial property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) 2019:

Land	$164,464
Improvements	$939,307
Total	$1,103,771

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) 2019:

Land	$164,464
Improvements	$785,536
Total	$950,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) 2019.

DATED this: July 24, 2020

Petitioner's Representative

Property Tax Advisors, Inc.
3090 S. Jamaica Ct., #204
Aurora, CO 80014
Tel: 303.368.0500
Email: propertytax@cotaxes.net

Susan Schilling

Digitally signed by Susan Schilling
DN: cn=Susan Schilling, o=Adams County Assessor, ou=Commercial/Industrial Department, email=sschilling@adcogov.org, c=US
Date: 2020.07.17 10:18:24 -06'00'

Assessor Representative
Adams County Assessor's Office

ADAMS COUNTY ASSESSOR'S RECOMMENDATION WORKSHEET
BOARD OF COUNTY COMMISSIONERS (BOCC)

Account No : **R0077815** Parcel No : **0172131205002**
Petition Year : **2019** Petition Filed Date : **April 27, 2020**
Owner Entity : **MILES FAMILY LIMITED LIABILITY PARTNERSHIP**
Owner Address : **6969 E. 11th Ave**
Owner City : **Denver** State : **CO**
Property Location : **7725 Dahlia St**

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL		L: $123,859		L: **$123,859**	**$35,920**	A. Ratio	**29.00%**
		I: $760,536		I: **$939,307**	**$272,400**	Mill Levy	**86.799**
TOTALS :		**$884,395**	**$256,470**	**$1,063,166**	**$308,320**	Original Tax	**$26,762**

Petitioner's Statement :

Property is valued too high

Assessor's Report

Situation :

Action :

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		**RECOMMENDED VALUE**		**REVISED TAX WARRANT**	
		Actual Value	Assessed Value	**Actual Value**	**Assessed Value**	Tax Refund	
REAL	0	L: **$123,859**	**$35,920**	L: **$123,859**	**$35,920**		**$3,870.37**
		I: **$939,307**	**$272,400**	I: **$785,536**	**$227,810**	Revised Tax	
TOTALS :		**$1,063,166**	**$308,320**	**$909,395**	**$263,730**		**$22,891.50**

Susan Schilling — August 6, 2020
Appraiser — Date

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received _____
(Use Assessor's or Commissioners' Date Stamp)

Section I: Petitioner, please complete Section I only.

Date: 3/1/20
Month Day Year

Petitioner's Name: Miles Family LLLP

Petitioner's Mailing Address: 6969 E. 11th Ave.

Denver	CO	80220
City or Town	State	Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
R0077815	7725 Dahlia St.
R0077814	Vacant Land

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

The income and market approaches to value support a lower valuation.

Petitioner's estimate of value: $925,100.00 (2019)
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

_____ Daytime Phone Number (_____)
Petitioner's Signature

Email _____

By _____ Daytime Phone Number (303) 368.0500
Agent's Signature*

Printed Name: Dariush Bozorgpour Email propertytax@cotaxes.net

Property Tax Advisors, Inc.

***Letter of agency must be attached when petition is submitted by an agent.**

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ **Protest?** ☐ **No** ☐ **Yes (If a protest was filed, please attach a copy of the NOD.)**

☐ **Assessor recommends denial for the following reason(s):**

_____
Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/17

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature **Date**

_____ _____
Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on _____/_____/_____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ (***being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

Agent: **PROPERTY TAX ADVISORS, INC.**
3090 South Jamaica Court, Suite 204
Aurora, Colorado 80014
Tel: 303.368.0500 Fax: 303.368.0573
Email: propertytax@cotaxes.net

Subject: **APPEAL OF REAL PROPERTY VALUATION**

Tax Year: 2019

County: Adams

Schedule Number: R0077815 / R0077814 PTA # 6279

Property Address: 7725 Dahlia St. / Vacant Land

Property Owner: Miles Family LLLP
Mailing Address: 6969 E. 11th Ave.
Denver, CO 80220

Inclusions:

X	Photograph(s) of Subject Property
	Correlation and Conclusions
X	Income Approach
	Market Sales
	Cost Approach
X	Salient Facts

Report Date: 3/1/20 ___ **OWNER OCCUPIED**

PETITIONER'S FINAL ESTIMATE OF VALUE: $925,100

Value per Square Foot: $81.75

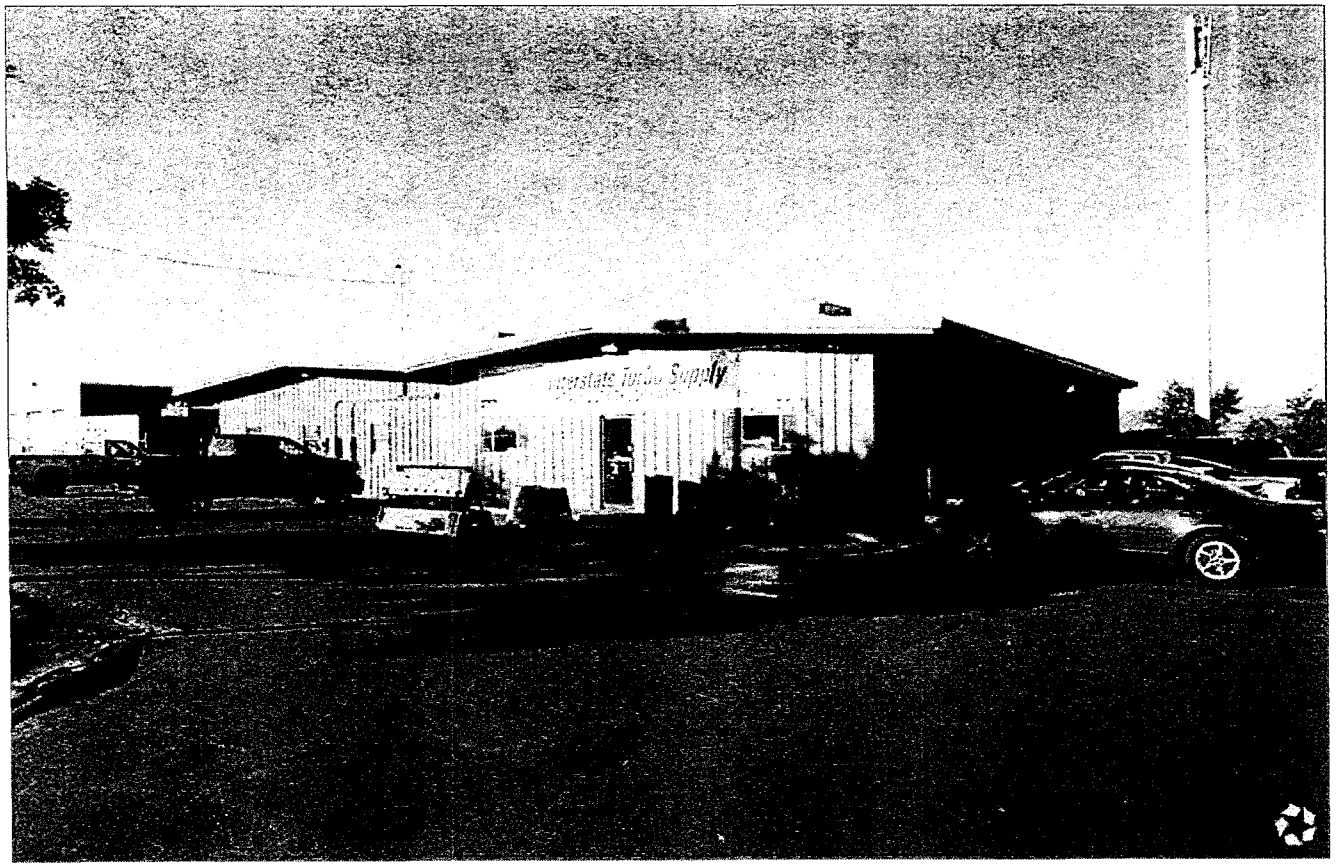
ASSESSOR'S VALUE: $1,103,771

Value per Square Foot: $97.54

Site Size	28,749 s.f.	YOC	1979/2001/2017	Effective Bldg. Age (yrs)	25
Gross Building Area	11,316 s.f.			Remaining Econ. Life (yrs)	15
Land to Bldg. Ratio	2.54 :1	Zoning	Industrial	Construction	
Use:	Industrial				

Bldg. 1: 9,000sf / Bldg. 2: 816sf / Bldg. 3: 1,500sf – Assessor records are showing the bldg. at 4,279sf

7725 Dahlia St



Salient Facts

The assessor's records are showing building 3 at 4,279 s.f. The building is approx. 1,800 s.f.

Rental Rate: $0.00 /sf 3250

Source: Owner provided income and expense

Factors Affecting Rental Rate:

0	sf x	$0.00	/sf =	$0
0	sf x	$0.00	/sf =	$0
0	sf x	$0.00	/sf =	$0

Potential Gross Income $ 0

Source: Annualized 2017 and 2018 Actual Income

Occupancy Rate X 0.95

Effective Gross Income $ 83,117

Source: Annualized 2017 and 2018 Actual Expense (R.E. Taxes & Dep. Excluded)

Expenses - 13,732

Net Operating Income $ 69,386

Source:

Cap Rate	7.50%
*ETR	0.00%
Overall Rate	**7.50%**

Capitalization Rate ÷ 0.075

VALUE BY INCOME APPROACH $ 925,142

Say $ 925,100

Mill Levy	0
Assessment Rate	0.29
**ETR*	0.000

Revenue:	**2017**	**2018**
Total	$ 87,288	$ 74,776
Annualized:	**$ 83,117**	
Expenses:	2017	2018
Expenses:		
Total	$ 15,002.00	$ 11,191.00
Total:	$15,002	$11,191
Annualized:	$13,732	

Comments:

2017

Form **8825** (Rev. September 2017)
Department of the Treasury
Internal Revenue Service

Rental Real Estate Income and Expenses of a Partnership or an S Corporation

Attach to Form 1065, Form 1065-B, or Form 1120S.
Go to *www.irs.gov/Form8825* for the latest information.

OMB No. 1545-0123

Name: **MILES FAMILY, LLLP**

Employer identification number: **36-4526500**

1 Show the type and address of each property. For each rental real estate property listed, report the number of days rented at fair rental value and days with personal use. See instructions. See page 2 to list additional properties.

	Physical address of each property—street, city, state, ZIP code	Type—Enter code 1-6; see page 2 for list	Fair Rental Days	Personal Use Days
(A)	COMMERCIAL BUILDING 7725 DAHLIA STREET COMMERCE CITY CO 80037	4 COMMERCIAL	365	
B	ANNA MARIA TOWNHOME 102 2ND STREET NORTH UNIT B HOLMES BEACH FL 34217	1 SINGLE FAM RESIDENCE	365	
C	E 77TH AVE 5253 AND 5215 EAST 77TTH AVE COMMERCE CITY CO 80022	4 COMMERCIAL	365	
D	523 JOSEPHINE 523 JOSEPHINE ST DENVER CO 80206	1 SINGLE FAM RESIDENCE	365	

	Rental Real Estate Income		Properties A	B	C	D
2	Gross rents	2	87,288	30,332	56,812	9,588
	Rental Real Estate Expenses					
3	Advertising	3				
4	Auto and travel	4				
5	Cleaning and maintenance	5	35	2,742	35	105
6	Commissions	6		7,284		
7	Insurance	7	4,651	-123		
8	Legal and other professional fees	8	950	950	950	1,363
9	Interest	9			9,057	
10	Repairs	10	287	782	6,610	142
11	Taxes	11	228	5,385	8,097	-1,430
12	Utilities	12		2,435	339	55
13	Wages and salaries	13				
14	Depreciation (see instructions)	14	10,476	7,314	15,719	19,146
15	Other (list) SEE STMT 2,3,4,5	15	123	9,649	68,451	251
	10% mgt fee imputed		8,728			
16	Total expenses for each property. Add lines 3 through 15	16	16,750	36,418	109,258	19,632
17	Income or (loss) from each property. Subtract line 16 from line 2	17	70,538	-6,086	-52,446	-10,044

18a	Total gross rents. Add gross rents from line 2, columns A through H	18a	184,020
b	Total expenses. Add total expenses from line 16, columns A through H	18b	(182,058)
19	Net gain (loss) from Form 4797, Part II, line 17, from the disposition of property from rental real estate activities	19	
20a	Net income (loss) from rental real estate activities from partnerships, estates, and trusts in which this partnership or S corporation is a partner or beneficiary (from Schedule K-1)	20a	
b	Identify below the partnerships, estates, or trusts from which net income (loss) is shown on line 20a. Attach a schedule if more space is needed.		
	(1) Name — (2) Employer identification number		
21	Net rental estate income (loss). Combine lines 18a through 20a. Enter the result here and on: ● **Form 1065 or 1120S:** Schedule K, line 2; or ● **Form 1065-B:** Part I, line 4	21	1,962

2018

Form **8825** (Rev. November 2018)
Department of the Treasury
Internal Revenue Service

Rental Real Estate Income and Expenses of a Partnership or an S Corporation

▶ Attach to Form 1065 or Form 1120S.
▶ Go to *www.irs.gov/Form8825* for the latest information.

OMB No. 1545-0123

Name: MILES FAMILY, LLLP

Employer identification number: 36-4526500

1 Show the type and address of each property. For each rental real estate property listed, report the number of days rented at fair rental value and days with personal use. See instructions. See page 2 to list additional properties.

	Physical address of each property—street, city, state, ZIP code	Type—Enter code 1-8; see page 2 for list	Fair Rental Days	Personal Use Days
A	COMMERCIAL BUILDING 7725 DAHLIA STREET COMMERCE CITY CO 80037	4 COMMERCIAL	365	
B	E 77TH AVE 5253 AND 5215 EAST 77TTH AVE COMMERCE CITY CO 80022	4 COMMERCIAL	365	
C	523 JOSEPHINE 523 JOSEPHINE ST DENVER CO 80206	1 SINGLE FAM RESIDENCE	365	
D				

			Properties A	B	C	D
	Rental Real Estate Income					
2	Gross rents	2	74,776	75,267	38,088	
	Rental Real Estate Expenses					
3	Advertising	3				
4	Auto and travel	4				
5	Cleaning and maintenance	5	525		250	
6	Commissions	6	-20	-39	-20	
7	Insurance	7	1,089	2,177	2,718	
8	Legal and other professional fees	8	2,100	2,890		
9	Interest (see instructions)	9		8,666		
10	Repairs	10		1,150	1,839	
11	Taxes	11		9,139	2,186	
12	Utilities	12		339	200	
13	Wages and salaries	13				
14	Depreciation (see instructions)	14	7,506	12,102	34,642	
15	Other (list) ▶ SEE STMT 2,3,4 10% mgt fee imputed	15	111,381 7,477	15,694	75	
16	Total expenses for each property. Add lines 3 through 15	16	122,581	52,118	41,890	
17	Income or (loss) from each property. Subtract line 16 from line 2	17	-47,805	23,149	-3,802	

18a	Total gross rents. Add gross rents from line 2, columns A through H	18a	188,131
b	Total expenses. Add total expenses from line 16, columns A through H	18b	(216,589)
19	Net gain (loss) from Form 4797, Part II, line 17, from the disposition of property from rental real estate activities	19	
20a	Net income (loss) from rental real estate activities from partnerships, estates, and trusts in which this partnership or S corporation is a partner or beneficiary (from Schedule K-1)	20a	
b	Identify below the partnerships, estates, or trusts from which net income (loss) is shown on line 20a. Attach a schedule if more space is needed.		
	(1) Name — (2) Employer identification number		
21	Net rental real estate income (loss). Combine lines 18a through 20a. Enter the result here and on: • **Form 1065 or 1120S:** Schedule K, line 2	21	-28,458

STRUCTURAL NOTES

GENERAL:

1. Dimensions: The structural drawings shall be considered as a part of the complete set of Contract drawings, including the drawings of all disciplines. It is intended that the Structural drawings will provide sufficient dimensions to locate the primary structural elements and members. Location of secondary members which are affected by systems detailed by others may require reference to the drawings of other disciplines and layout and coordination by the contractor. If direct conflict between dimensions of two or more disciplines is encountered, such conflicts shall be resolved by the Architect. Do not use scaled dimensions. Use written dimensions or where dimensions are not provided, consult the architect for clarifications before proceeding with the work in question.

2. Omissions or conflicts between various elements of the drawings, specifications, notes, and details shall be brought to the attention of the structural engineer and resolved before proceeding with the work. The contractor must submit in writing any requests for modifications to the plans and specifications. Shop drawings submitted to the structural engineer for review do not constitute "in writing" unless it is clearly noted that specific changes are being requested.

3. Deferred Submittals: Where Structural components are fully or partially designed and detailed by the supplier or fabricator, complete shop drawings and calculations, signed and sealed by a professional engineer registered in the state where the project is located, shall be submitted to the structural engineer for review. In addition, a copy of these documents shall be submitted to the Building Official for approval in accordance with IBC Section 107.3.4.1.

4. The Contract drawings and specifications represent the finished structure. They do not indicate the method of construction. The contractor shall provide all measures necessary to protect the structure during construction. Such measures shall include but not be limited to bracing and shoring for loads due to construction equipment and materials.

DESIGN CRITERIA:

1. 1. Used 2012 International Building Code.
2. ASD Design Loads:
   A. Roof: D.L. = 5#/SF., L.L. = 30#/SF. Snow
3. Wind load = 90 MPH (nominal), exposure C, Iw = 1.0.
4. Seismic: Equivalent Static Force Design Procedure.
   Seismic Design Category B, Site Class D.
   Ss = 0.176 SDS = 0.188
   S1 = 0.057 SD1 = 0.092
   R = 7.0 – Light framed walls w/ steel sheet shear panels.
   Ie = 1.0.

**Per 2012 ICC Commentary:

"Wind speeds are designated as "ultimate design" or "nominal design" wind speeds and are used for either strength design or allowable stress designs respectively. The ultimate design wind speeds are indicated in Figures 1609A, B & C, and vary based on the building's risk category and location. The ultimate design for wind speeds for a Risk Category II building vary from 110 mph on the West Coast to 180 mph in hurricane-prone areas in southern Florida. These wind speeds would convert to a nominal design wind speed, or what was previously called the "basic wind speed" 85 mph for the West Coast and 139 mph for southern Florida when using allowable stress design."

QUALITY ASSURANCE:

FOUNDATIONS:

1. Maximum foundation soil bearing pressure used = 1500#/SF.

MATERIALS:

CONCRETE:

1. Mix design shall be established in accordance to Chapter 5 of ACI 318.
2. Minimum cement content = 376#/YD.
3. Maximum slump = 4".
4. 28 day strength f'c = 2500 PSI.
   Special inspection not required per IBC 1705.3, exception 2.

STRUCTURAL AND MISCELLANEOUS STEEL:

1. All steel work shall conform with AISC specifications.
2. Bolts ASTM A307 for connections to concrete.
   Bolts ASTM A325 for steel to steel connections. Bolts to be snug tight except bolts indicated as S.C. to be fully tightened.
3. Roof Steel shall be painted 29 Ga, ribbed steel and shall be attached to framing with 1 ½" x #9 screws with neoprene washers at 9" o.c.
4. Wall Steel shall be painted 29 Ga, ribbed steel and shall be attached to framing with 1 ½" x #9 screws with neoprene washers at 9" o.c.

LUMBER:

1. Sawn lumber for studs, joists, etc.(2x6 or larger) = No.2 Doug Fir larch.
2. 2x4's = Standard Doug Fir larch.
3. Posts = So. Pine #1 Nail-lam.
4. All nails are to be common nails unless noted otherwise.
5. For connections of "SIMPSON" hardware or equivalent follow manufacturers recommendations.
6. Trus-Joist products:
   A. Roof joists shown as TJI etc. shall be designed for the loads specified and shall conform to Trus-Joist specification.
   B. Joists exceeding 24' in length shall be cambered to a standard radius of R = 2250.
   C. Any alternate joist system(s) shall be the same depth and load Carrying capacity as the Trus-Joist system show on the drawings.
   D. Micro Lam (LVL) E-1,900,000 psi.
7. Premanufactured Trusses
   A. Truss Loading:
      Top Chord D.L. = 5 PSF.
      Bottom Chord D.L. = 5 PSF.
      Top Chord L.L. = 30 PSF.
      Bottom Chord L.L. = 5 PSF. Does not act concurrently with top chord L.L.
   B. Member Properties:
      Chords shall be #2 Douglas Fir or better.
      Webs shall have minimum Modulus of Elasticity of 1,500,000 psi.
   C. All truss blocking shall be provided by the truss manufacturer and constructed with approved plates.
   D. Truss Manufacturer shall verify all truss dimensions, accounting for tolerances, connections, and splice requirements.
   E. Truss profiles shown are representations of possible configurations of Web locations and member sizes. Truss manufacturer shall submit shop drawings for approval. All trusses shall be designed by a registered professional engineer and all shop drawings shall be stamped and signed by a registered professional engineer.
   F. Truss manufacturer shall provide proof of approved third party I inspection as required by IBC chapter 2303.4.
   G. Truss manufacturer shall design all truss to truss connections and shall indicate said connections on the shop drawings.
   H. Each truss shall be marked with the following information:
      1. Manufacturers identity.
      2. Design Load.
      3. Truss spacing.
8. All lumber in contact with concrete, masonry, or ground shall be preservative treated wood in accordance with AWPA standards.

COLORADO LICENSED
BRIAN WADDELL
6/14/16
44610
PROFESSIONAL ENGINEER

P.O. BOX 895
POST FALLS, IDAHO
PH: 800-833-9997
FAX: 208-777-8597

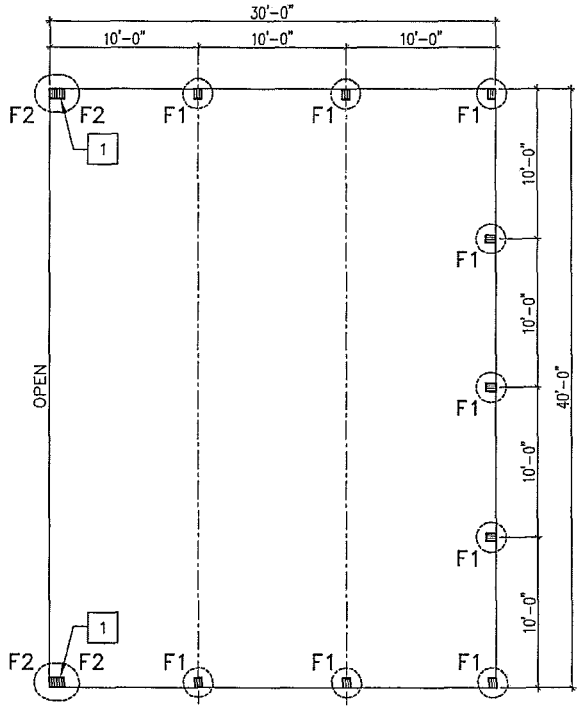
STRUCTURAL NOTES

NO.	REVISIONS	DATE

STEEL STRUCTURES AMERICA INC.

POST FRAME BLDG FOR:
FLEET PRIDE
COMMERCE CITY, COLORADO
7725 DAHLIA STREET

DRAWN	BW
DATE	6/13/16
JOB NO.	8952
SHEET	S0



FOUNDATION PLAN

SCALE: 1/8" = 1'-0"

FOUNDATION NOTES:

1. BOLT (2) POSTS TOGETHER w/ 3/4"ø BOLTS @ 24" O.C.

FOOTING SCHEDULE				
MARK	"D"	DEPTH	POST	DETAIL
F1	2'-0"ø	4'-0"	(3) 2x8 So. Pine #1 Nail-lam	2/S3
F2	2'-6"ø	4'-0"	(3) 2x8 So. Pine #1 Nail-lam	2/S3
F3	–	–	–	–
F4	–	–	–	–

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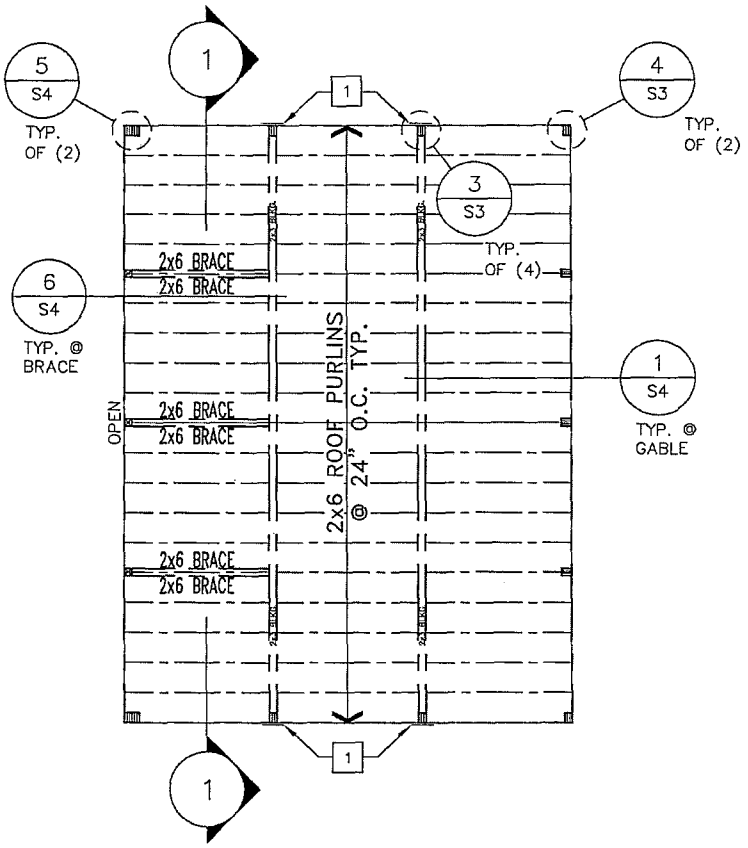
FOUNDATION PLAN

NO.	REVISIONS	DATE

STEEL STRUCTURES AMERICA INC.

POST FRAME BLDG FOR:
FLEET PRIDE
7725 DAHLIA STREET
COMMERCE CITY, COLORADO

DRAWN	BW
DATE	6/13/16
JOB NO.	8952
SHEET	S1



ROOF FRAMING PLAN

SCALE: 1/8" = 1'-0"

ROOF FRAMING NOTES:

1 LSTA18 STRAP– PLACE AT INSIDE OF FASCIA BOARD IF NO OVERHANGS. PLACE AT INSIDE FACE OF TOP WALL GIRT IF OVERHANGS

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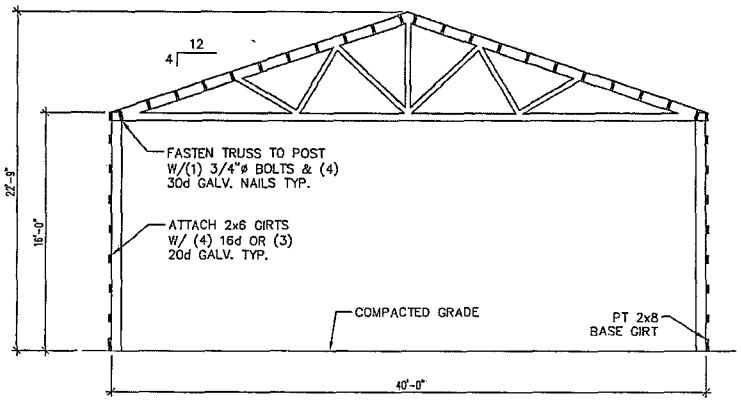
ROOF FRAMING PLAN

NO.	REVISIONS	DATE

STEEL STRUCTURES AMERICA INC.

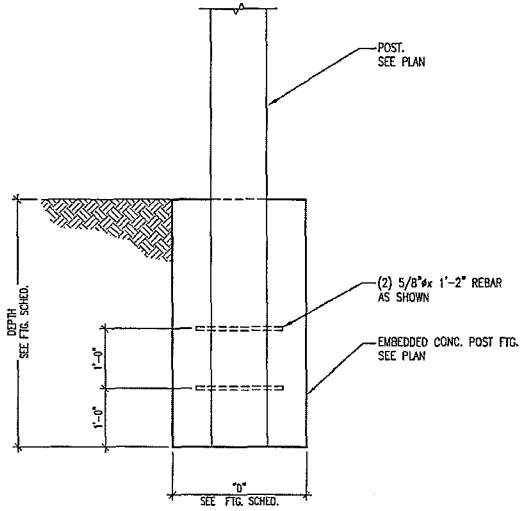
POST FRAME BLDG FOR:
FLEET PRIDE
COMMERCE CITY, COLORADO
7725 DAHLIA STREET

DRAWN	BW
DATE	6/13/16
JOB NO.	8952
SHEET	S2



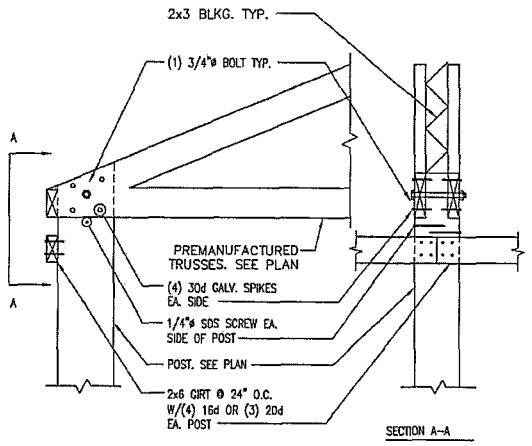
1 SECTION 1-1

SCALE: 1/8" = 1'-0"



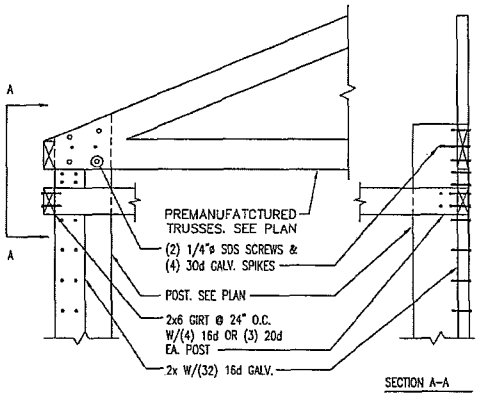
2 POST FOOTING

SCALE: 1/2"=1'-0"



3 MAIN FRAME TRUSS BEARING DETAIL

SCALE: 1/2"=1'-0"



4 GABLE END TRUSS BEARING DETAIL

SCALE: 1/2"=1'-0"

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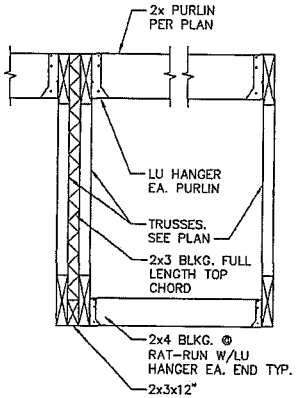
BLDG. SECTION AND FRAMING DETAILS

NO.	REVISIONS	DATE

STEEL STRUCTURES AMERICA INC.

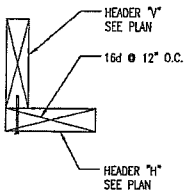
POST FRAME BLDG FOR:
FLEET PRIDE
COMMERCE CITY, COLORADO
7725 DAHLIA STREET

DRAWN	BW
DATE	6/13/16
JOB NO.	8952
SHEET	S3



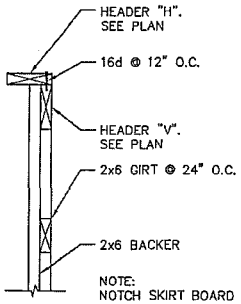
1 GABLE TRUSS FRAMING DETAIL

SCALE: 1/2"=1'-0"



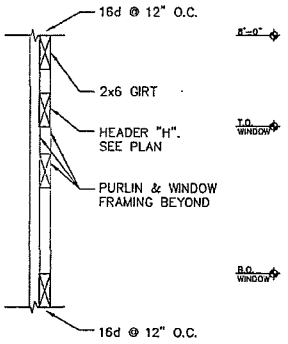
2 HEADER DETAIL

SCALE: 1"=1'-0"



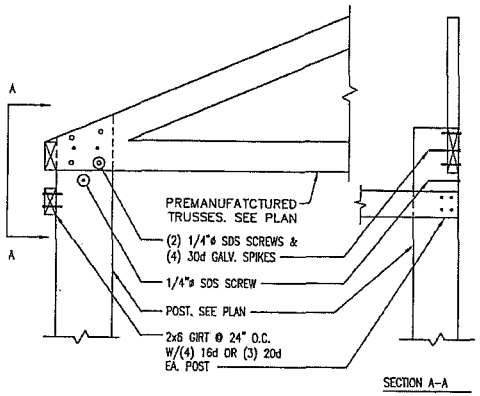
3 MAN DOOR HEADER DETAIL

SCALE: 1/2"=1'-0"



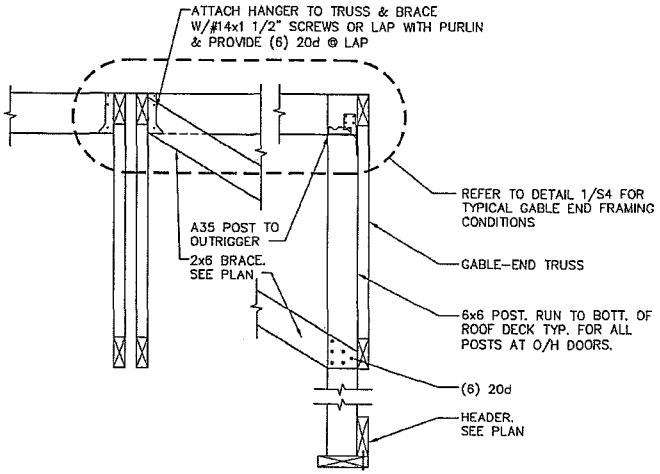
4 WINDOW HEADER DETAIL

SCALE: 1/2"=1'-0"



5 GABLE END TRUSS BEARING DETAIL

SCALE: 1/2"=1'-0"



6 2x6 BRACE DETAIL

SCALE: 1/2"=1'-0"

COLORADO LICENSED BRIAN WADDELL 6/14/16 44610 PROFESSIONAL ENGINEER

FRAMING DETAILS

NO.	REVISIONS	DATE

STEEL STRUCTURES AMERICA INC.

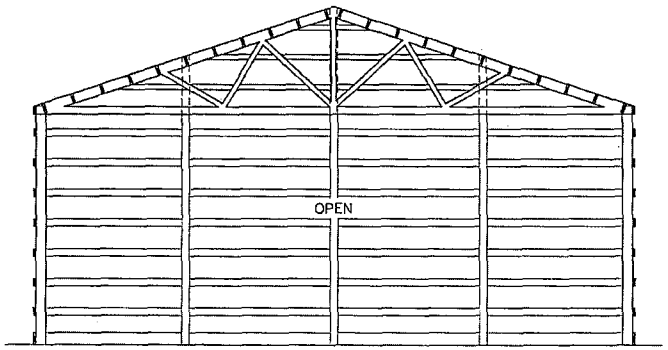
POST FRAME BLDG FOR:

FLEET PRIDE

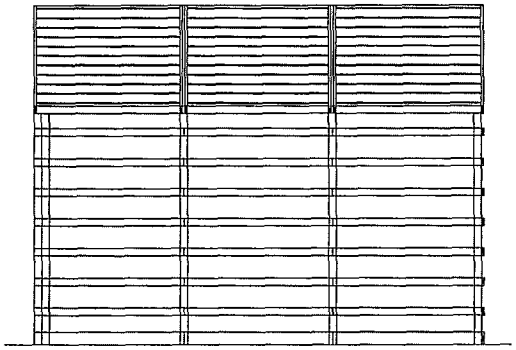
7725 DALIA STREET

COMMERCE CITY, COLORADO

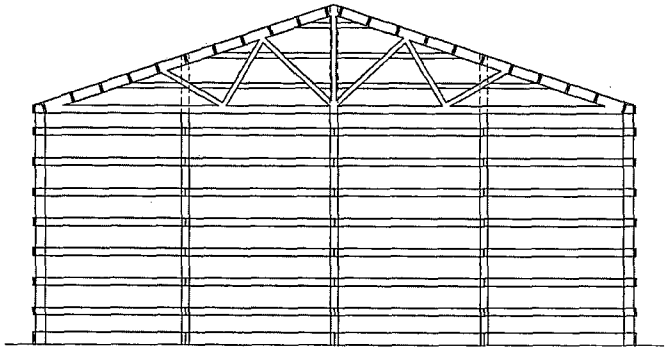
DRAWN	BW
DATE	6/13/16
JOB NO.	8952
SHEET	S4



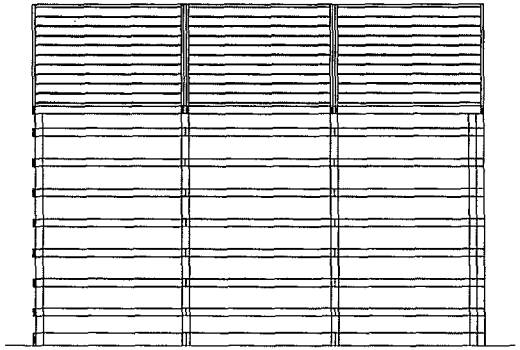
1 FRONT ELEVATION
SCALE: 1/8" = 1'-0"



2 RIGHT ELEVATION
SCALE: 1/8" = 1'-0"



3 BACK ELEVATION
SCALE: 1/8" = 1'-0"



4 LEFT ELEVATION
SCALE: 1/8" = 1'-0"

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BRIAN WADDELL
6/14/16
44610
PROFESSIONAL ENGINEER

ELEVATIONS

NO.	REVISIONS	DATE

STEEL STRUCTURES AMERICA INC.

POST FRAME BLDG FOR:
FLEET PRIDE
7725 DAHLIA STREET
COMMERCE CITY, COLORADO

DRAWN	BW
DATE	6/13/16
JOB NO.	8952
SHEET	S5

Property Tax Advisors, Inc.
3090 S. Jamaica Ct., Suite 204
Aurora, Colorado 80014

(303)368-0500
FAX (303)368-0573
Email: propertytax@cotaxes.net

CONSULTANT - AGENCY AGREEMENT

☐ a Corporation
☐ a Partnership
☐ as Individuals
☐ a Trust
☑ LLC

Property Owner: Miles Family LLLP

County: Adams

P.I.N.	Property Address
R0077815	7725 Dahlia St.
R0077814	Vacant Land

The undersigned hereby appoints and authorizes Property Tax Advisors, Inc. as its Agent and Consultant in the preparation and execution of a real estate valuation appeal(s) on behalf of the undersigned in regard to the above enumerated property(ies) for the 2020 tax year and for the prior two years. The undersigned further authorizes Property Tax Advisors, Inc., as Agent of the undersigned, to execute and cause to be filed on behalf of the undersigned, in the name of the undersigned, any and all documents relating to an appeal of the subject property's(ies') valuation(s).

This agreement is executed this 10th day of February, 2020.

BY: _____

Print Name: Daniel C Miles

Title: Owner
(If Corporation, your title; (or) Owner, General Partner, Lessee, Power of Attorney, Trustee, etc.

Telephone No.: 303-907-9251

Fax No.: _____

Please check the appropriated line

☐ Property is Owner Occupied

☑ Property is Leased to Tenants

If property is partially owner occupied and partially leased please check both lines.

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

COUNTY BOARD OF EQUALIZATION

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0118564 Parcel N0.(S) 0172115301004

2. The subject property is classified as a Commercial property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$2,513,957
Improvements	$408,172
Total	$2,922,129

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$2,513,957
Improvements	$247,043
Total	$2,761,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: July 13, 2020

Petitioner's Representative
David Johnson
Joseph C Sansone Company
18040 Edison Avenue
Chesterfield, MO 63005

Deb Myer
Digitally signed by Deb Myer
DN: cn=Deb Myer, o=Adams County, ou=Assessor's Office, email=dmyer@adcogov.org, c=US
Date: 2020.07.13 12:46:17 -06'00'

Assessor Representative
Adams County Assessor's Office

ASSESSOR'S RECOMMENDATION
BOARD OF COUNTY COMMISSIONERS

Account No : R0118564 Parcel No : 0172115301004
Petition Year : 2019 Date Filed : April 27, 2020
Owner Entity : Triad Enterprises, LLC
Owner Address : 181 E 56th Ave Suite 301
Owner City : Denver State : CO 80216
Property Location : 9001 E 96 Ave, Commerce City, CO

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	344	L: $2,300,000	**$667,000**	L: **$2,513,957**	**$729,050**	A. Ratio	29.00%
		I: **$20,000**	**$5,800**	I: **$408,172**	**$118,370**	Mill Levy	93.468
TOTALS :		**$2,320,000**	**$672,800**	**$2,922,129**	**$847,420**	Original Tax	**$79,206.65**

Petitioner's Statement :

Taxpayer's agent requests value of $2,320,000.

Assessor's Report

Situation :

Reviewed the taxpayer submittal documents. Requested the agent get a copy of the lease and the lease addendum on the property. Reviewed sales, cost, and income. Considered the actual rents collected on the property. High land to building ratio.

Recommendation : ***$2,761,000***

Upon further review, recommend valuation reduction.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value	Tax Refund	
REAL	1344	L: **$2,513,957**	**$729,050**	L: **$2,513,957**	**$729,050**		**$4,367.76**
		I: **$408,172**	**$118,370**	I: **$247,043**	**$71,640**	Revised Tax	
TOTALS :		**$2,922,129**	**$847,420**	**$2,761,000**	**$800,690**		**$74,838.89**

Deborah L. Myer July 15, 2020
Appraiser Date

#117403

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received: _____
(Use Assessor's or Commissioners' Date Stamp)

Section I: Petitioner, please complete Section I only.

Date: 02-12-2020
Month Day Year

Petitioner's Name: TRIAD ENTERPRISES LLC

Petitioner's Mailing Address: Joseph C Sansone Company, David Johnson, 16040 Edison Avenue

Chesterfield | MO | 63005
City or Town | State | Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
0172115301004	0 COMMERCE CITY
R0115648	

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year: 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

The Assessor's calculation of value exceeds the actual fair market value of the property.

Petitioner's estimate of value: $ See enclosed (2019)
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

_____ Daytime Phone Number: (___) _____
Petitioner's Signature

Email: _____

By: _____ Daytime Phone Number: (636) 733-5455
Agent's Signature*

Email: appeals@jsco.com

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S. denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision. § 39-10-114.5(1), C.R.S.

Section II: Assessor's Recommendation
(For Assessor's Use Only)

Tax Year: _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ Assessor recommends approval as outlined above.

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer. § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes. (If a protest was filed, please attach a copy of the NOD.)

☐ Assessor recommends denial for the following reason(s):

_____
Assessor's or Deputy Assessor's Signature

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY

(Section III or or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition. § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent taxes payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____

Petitioner's Signature Date

_____ _____

Assessor's or Deputy Assessor's Signature Date

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto. NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____

Chairperson of the Board of County Commissioners' Signature

I, _____, County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____

County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule per year must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby:

☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____

Secretary's Signature Property Tax Administrator's Signature Date

JOSEPH C. SANSONE COMPANY

Corporate Headquarters
18040 Edison Avenue
Chesterfield, MO 63005
1-800-394-0140

AGENT AUTHORIZATION

Colorado

TO: _____
Assessor's Office and the
Assessment Review Agency

The Property Owner(s) listed below hereby authorize and appoint the Joseph C. Sansone Company to act as agent with full authority to handle all matters relating to ad valorem tax matters for our respective listed parcels. This includes, but is not limited to, the filing of property tax declarations or other documents with you or the Assessment Appeals Board, examining any records in your office which we have a right to examine, appearing before any assessment officer or board and discussing assessments and resolving disputes with you concerning the assessments on parcels for which we are responsible for the property taxes. This authority shall terminate when all matters relating to the 2016 through 2020 assessments are resolved.

Exact Name of Property Owner	Parcel Number	Schedule/PIN/Account (if applicable)
TRIAD ENTERPRISES LLC	R0118564	

R. Wayne Holder
AUTHORIZED SIGNATURE

R. Wayne Holder
PRINT NAME OF AUTHORIZED SIGNER

3-21-18
DATE

CO-owner
TITLE

State of Colorado
City/County of ADAMS

On this 21 day of MARCH 2018 before me, the undersigned, personally appeared R. WAYNE HOLDER known to me (or satisfactorily proven) to be the person whose name is subscribed to within this instrument and acknowledged that he executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

Notary Public _____

PAMELA C SAYLER
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20044026570
MY COMMISSION EXPIRES 07/29/2019

REVISED 06/15

REAL PROPERTY SUMMARY ANALYSIS
OF

Triad Enterprises LLC

9001 East 96th Avenue

Commerce City, CO 80640

Parcel ID(s)

0172115301004

Appeal Number

Prepared By:

JOSEPH C. SANSONE COMPANY
18040 Edison Avenue
Chesterfield, Missouri 63005
<This is not an appraisal>

Property Issues

9001 East 96th Avenue

PTR Number: 19322950001CO

Location IDs: 0172115301004

Area Type	WAREHOUSE						Location Totals	
Gross Building Area		8,400						8,400
Net Leaseable Area		8,400						8,400
Potential Gross Income	8.00	67,200					8.00	67,200
Vacancy and Credit Loss	5.0%	3,360					5.0%	3,360
Effective Gross Income		63,840						63,840
Overall Expense	10.0%	6,384					10.0%	6,384
Net Operating Income		57,456						57,456
Base Cap Rate								7.500
Adj Tax Rate								0.140
Adj Cap Rate								7.640
Value Sum								752,032
Excess land - 12 acres @ 53.00 per SF								1,569,000
Indicated value								2,320,000
Total Indicated Value per SF(NLA)								276.19

6300 E 58th Ave - Park Industrial Center

Location:	East I-70/Montbello Ind Cluster East I-70/270 Ind Submarket Adams County Commerce City, CO 80022	Building Type:	Class C Warehouse
		Status:	Built 1999
		Tenancy:	Multiple Tenant
		Land Area:	9 AC
		Stories:	1
		RBA:	30,000 SF
Management:	KEW Realty Corporation		
Recorded Owner:	KEW Realty Corporation	Total Avail:	10,000 SF
		% Leased:	66.7%
Ceiling Height:	18'0" - 20'0"	Crane:	None
Column Spacing:	25'w x 50'd	Rail Line:	None
Drive Ins:	6 - 12'0"w x 14'0"h	Cross Docks:	None
Loading Docks:	6 ext	Const Mat:	Masonry
Power:	900a/120-220v 3p/3w	Utilities:	Heating

Expenses: 2012 Tax @ $2.63/sf
Parcel Number: 1823-08-3-02-084
Parking: 30 free Surface Spaces are available; Ratio of 1.00/1,000 SF

Floor	SF Avail	Bldg Contig	Rent/SF/Yr + Svc	Occupancy	Term	Use Type
P 1st / Suite 6300I	10,000/1,500 offc	10,000	$8.00/mnth	Vacant	Negotiable	Direct

6000 E 49th Ave - Stapleton Industrial Center

Location	Stapleton Industrial Center SWC 49th/50th East I-70/Montbello Ind Cluster East I-70/270 Ind Submarket Adams County Commerce City, CO 80022	Building Type	Class C Warehouse
		Status	Built 1985
		Tenancy	Multiple Tenant
		Land Area	3 AC
		Stories	1
		RBA	77,444 SF
Management	-		
Recorded Owner	Stapleton Indust. Center Assoc	Total Avail.	35,143 SF
		% Leased	100%
Ceiling Height	18'0"	Crane	None
Column Spacing	-	Rail Line	None
Drive Ins	2 - 100"w x 14'0"h	Cross Docks	None
Loading Docks	11 ext	Const Mat	Masonry
Power	110-220v 3p	Utilities	-

Expenses: 2017 Tax @ $1.16/sf, 2013 Ops @ $0.63/sf
Parcel Number: 1823-17-3-04-053
Parking: Free Surface Spaces; Ratio of 0.90/1,000 SF

Floor	SF Avail	Bldg Contig	Rate/SF/Yr - Svc	Occupancy	Term	Use/Type
P 1st / Suite 10	7,235	15,170	$7.50/mnth	03/2019	Negotiable	Direct
P 1st / Suite 11	7,935	15,170	$7.50/mnth	03/2019	Negotiable	Direct
P 1st / Suite 12-13	7,515	19,973	$7.50/mnth	03/2019	Negotiable	Direct
P 1st / Suite 14	12,458	19,973	$7.00/mnth	03/2019	Negotiable	Direct

6751-6785 E 50th Ave - E. 50th Avenue Complex

Location	E. 50th Avenue Complex AKA Newport St N side of 50th at Newport East I-70/Montbello Ind Cluster East I-70/270 Ind Submarket Adams County Commerce City, CO 80022	Building Type	Class B Warehouse
		Status	Built 1975
		Tenancy	Multiple Tenant
		Land Area	4.50 AC
		Stories	2
		RBA	67,700 SF
Management	-		
Recorded Owner	6755 E 50th Avenue Llc	Total Avail	14,292 SF
		% Leased	89.4%
Ceiling Height	20'0"	Crane	None
Column Spacing	-	Rail Line	None
Drive Ins	17 - 10'0" w x 10'0" h	Cross Docks	None
Loading Docks	7 ext	Const Mat	Reinforced Concrete
Power	400-600a/110-480v 3p	Utilities	Lighting

Expenses	2012 Tax @ $0.74/sf; 2011 Ops @ $0.52/sf
Parcel Number	1823-17-4-00-011
Parking	100 Surface Spaces are available; Ratio of 1.48/1,000 SF
Amenities	Cooler, Fenced Lot

Floor	SF Avail	Bldg Contig	Rent/SF/Yr - Svc	Occupancy	Term	Use/Type
P, 1st / Suite 6769	7,146	7,146	$6.95/mth	Vacant	Negotiable	Direct
P, 1st / Suite 6769	7,146/774 ofc	7,146	$6.95/mth	06/2019	Negotiable	Direct

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

BOARD OF COUNTY COMMISSIONERS

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0121751 Parcel N0.(S) 0182510201006

2. The subject property is classified as a Commercial property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$1,705,374
Improvements	$1,307,726
Total	$3,013,100

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$1,705,374
Improvements	$794,626
Total	$2,500,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: July 21, 2020

Petitioner's Representative

Susan Schilling

Digitally signed by Susan Schilling
DN: cn=Susan Schilling, o=Adams County Assessor, ou=Commercial/Industrial Department, email=sschilling@adcogov.org, c=US
Date: 2020.07.17 10:18:24 -06'00'

Assessor Representative
Adams County Assessor's Office

ADAMS COUNTY ASSESSOR'S RECOMMENDATION WORKSHEET
BOARD OF COUNTY COMMISSIONERS (BOCC)

Account No : **R0121751** Parcel No : **01825-10-2-01-006**
Petition Year : **2019** Petition Filed Date : **December 30, 2019**
Owner Entity : **WEST 62ND AVE LLC**
Owner Address : **7010 Broadway STE 107**
Owner City : **Denver** State : **CO**
Property Location : **605 W. 62nd Ave**

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL		L: $1,705,374		L: **$1,705,374**	**$494,560**	A. Ratio	**29.00%**
		I: $431,626		I: **$1,307,626**	**$379,210**	Mill Levy	**99.960**
TOTALS :		**$2,137,000**	**$619,730**	**$3,013,000**	**$873,770**	Original Tax	**$87,342**

Petitioner's Statement :

Property is valued too high

Assessor's Report

Situation :

Action :

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		RECOMMENDED VALUE		REVISED TAX WARRANT	
		Actual Value	Assessed Value	**Actual Value**	**Assessed Value**	Tax Refund	
REAL	0	L: **$1,705,374**	**$494,560**	L: **$1,705,374**	**$494,560**		**$14,871.05**
		I: **$1,307,626**	**$379,210**	I: **$794,626**	**$230,440**	Revised Tax	
TOTALS :		**$3,013,000**	**$873,770**	**$2,500,000**	**$725,000**		**$72,471.00**

Susan Schilling — July 22, 2020
Appraiser — Date

117442

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received: _____
(Use Assessor's or Commissioners' Date Stamp)

Section I: **Petitioner, please complete Section I only.**

Date: 02-12-2020
Month Day Year

Petitioner's Name: WEST 62ND AVE LLC

Petitioner's Mailing Address: Joseph C Sansone Company, David Johnson 18040 Edison Avenue

Chesterfield | MO | 63005
City or Town | State | Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
0182510201006 R0121751	605 W 62nd Ave

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

The Assessor's calculation of value exceeds the actual fair market value of the property.

Petitioner's estimate of value: $ See enclosed (2019)
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

_____
Petitioner's Signature

Daytime Phone Number: (_____) _____

Email: _____

By: _____
Agent's Signature*

Daytime Phone Number: (636) 735-5455

Email: appeals@csco.com

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-118, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision. § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year: _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ Assessor recommends approval as outlined above.

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer. § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ Assessor recommends denial for the following reason(s):

_____
Assessor's or Deputy Assessor's Signature

DPT-AP No. 0210-8

2135245000ICO

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY

(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition. § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____

Petitioner's Signature **Date**

_____ _____

Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____ (Month / Day / Year), at which meeting there were present the following members:

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ (Name) ***(being present--not present)*** and Petitioner _____ (Name) ***(being present--not present)***, and WHEREAS, the said County Commissioners have carefully considered the within petition, and are fully advised in relation thereto; NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____

Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____ (Month / Year).

_____

County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby:

☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____

Signature of Assessor Property Tax Administrator's Signature Date

JOSEPH C. SANSONE COMPANY
Business Tax Solutions®

Corporate Headquarters:
18040 Edison Avenue
Chesterfield, MO 63005
1-800-594-0340

AGENT AUTHORIZATION

Colorado

TO: _____
Assessor's Office and the
Assessment Review Agency

The Property Owner(s) listed below hereby authorize and appoint the Joseph C. Sansone Company to act as agent with full authority to handle all matters relating to ad valorem tax matters for our respective listed parcels. This includes, but is not limited to, the filing of property tax declarations or other documents with you or the Assessment Appeals Board, examining any records in your office which we have a right to examine, appearing before any assessment officer or board and discussing assessments and resolving disputes with you concerning the assessments on parcels for which we are responsible for the property taxes. This authority shall terminate when all matters relating to the 2017 through 2022 assessments are resolved.

Exact Name of Property Owner	Parcel Number	Schedule/PIN/Account (if applicable)
WEST 62ND AVE LLC	0182510201006	R0121751

AUTHORIZED SIGNATURE

PRINT NAME OF AUTHORIZED SIGNER

12/20/19
DATE

Manager
TITLE

State of Colorado
City/County of _____

On this ____ day of _____, 20____ before me, the undersigned, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to within this instrument and acknowledged that he executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

Notary Public _____

REVISED 06/15

REAL PROPERTY SUMMARY ANALYSIS
OF

Starlight

605 W 62nd Ave

Denver, CO 80216

Parcel ID(s)

0182510201006

Appeal Number

Prepared By:

JOSEPH C. SANSONE COMPANY
18040 Edison Avenue
Chesterfield, Missouri 63005
<This is not an appraisal>

Property Issues

605 W 62nd Ave

PTR Number: 21352450001CO

Location IDs: 0182510201006

Area Type	WAREHOUSE		WAREHOUSE					Location Totals	
Gross Building Area		1,600		6,000					7,600
Net Leaseable Area		1,600		6,000					7,600
Potential Gross Income	9.00	14,400	9.00	54,000				9.00	68,400
Vacancy and Credit Loss	5.0%	720	5.0%	2,700				5.0%	3,420
Effective Gross Income		13,680		51,300					64,980
Overall Expense	10.0%	1,368	10.0%	5,130				10.0%	6,498
Net Operating Income		12,312		46,170					58,482
Base Cap Rate									7.500
Adj Tax Rate									0.145
Adj Cap Rate									7.645
Value Sum									764,981
Excess Land - 7 acres @ $4.50 per Land SF									1,372,000
Indicated Value									2,137,000
Total Indicated Value per SF(NLA)									281.18

6401 Broadway

Location:	NWC Broadway/64th Northwest Denver Ind Cluster Northwest Denver Ind Submarket Adams County Denver, CO 80221	Building Type:	Class C Warehouse
		Status:	Built 1964
		Tenancy:	Multiple Tenant
		Land Area:	2.35 AC
		Stories:	1
		RBA:	43,055 SF
Management:	-		
Recorded Owner:	Sixty-Four O One Broadway, LLC	Total Avail:	1,920 SF
		% Leased:	95.5%
Ceiling Height:	12'0"	Crane:	-
Column Spacing:	-	Rail Line:	None
Drive Ins:	18 - 10'0"w x 10'0"h	Cross Docks:	-
Loading Docks:	-	Const Mat:	Masonry
Power:	220-240a 3p	Utilities:	Heating - Gas, Sewer - City, Water - City

Expenses: 2018 Combined Tax/Ops @ $3.50/sf
Parcel Number: 1825-03-3-06-001
Parking: 60 free Surface Spaces are available. Ratio of 2.74/1,000 SF
Amenities: Air Conditioning

Floor	SF Avail	Max Contig	Rent/SF/Yr + Svc	Occupancy	Term	Use Type
P 1st / Suite D	1,920	1,920	$9.00/mth	Vacant	3 yrs	Direct

6850 Broadway - Clear Creek Business Park

Location:	AKA 70th Ave Northwest Denver Ind Cluster Northwest Denver Ind Submarket Adams County Denver, CO 80221	Building Type:	Class B Flex
		Status:	Built 1987, Renov 1989
		Tenancy:	Multiple Tenant
		Land Area:	0.80 AC
		Stories:	1
		RBA:	34,110 SF
Management:	Colliers International		
Recorded Owner:	WPC Clear Creek LLC	Total Avail:	5,086 SF
		% Leased:	100%
Ceiling Height:	16'0"	Crane:	-
Column Spacing:	-	Rail Line:	None
Drive Ins:	6 - 12'0"h	Cross Docks:	None
Loading Docks:	4 ext	Const Mat:	Reinforced Concrete
Power:	-	Utilities:	Gas - Natural, Heating, Sewer - City, Water - City

Expenses: 2013 Tax @ $1.50/sf; 2016 Ops @ $3.54/sf; 2015 Est Ops @ $3.45/sf
Parcel Number: 1825-03-1-03-028
Parking: 92 free Surface Spaces are available. Ratio of 2.70/1,000 SF

Floor	SF Avail	Bldg Contig	Rent/SF/Yr + Svc	Occupancy	Term	Use Type
P 1st / Suite E	5,086/1,017 ofc	5,086	$9.00/YR/I	30 Days	Negotiable	Direct

6870 N Broadway - Clear Creek Business Park

Location	AKA 70th Ave Northwest Denver Ind Cluster Northwest Denver Ind Submarket Adams County Denver, CO 80221	Building Type	Class C Flex
		Status	Built 1989
		Tenancy	Multiple Tenant
		Land Area	10.79 AC
		Stories	1
		RBA	15,725 SF
Management	Colliers International		
Recorded Owner	WPC Clear Creek LLC	Total Avail	2,012 SF
		% Leased	100%
Ceiling Height	14'0"	Crane	-
Column Spacing	-	Rail Line	None
Drive Ins	12 - 10'0"w x 12'0"h	Cross Docks	-
Loading Docks	None	Const Mat	Reinforced Concrete
Power	120-208v 3p	Utilities	-

Expenses: 2014 Combined Tax/Ops @ $3.37/sf; 2015 Est Ops @ $3.42/sf
Parcel Number: 1825-03-1-03-028
Parking: 52 free Surface Spaces are available. Ratio of 2.73/1,000 SF

Floor	SF Avail	Bldg Contig	Rent/SF/Yr + Svc	Occupancy	Term	Use Type
P 1st / Suite G	2,012/805 sh	2,012	$9.00/mth	04/2019	Negotiable	Direct

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

BOARD OF COUNTY COMMISSIONERS

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0147811 Parcel N0.(S) 0171934121015

2. The subject property is classified as a Commercial property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) 2019:

Land	202150
Improvements	1291638
Total	1493788

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) 2019:

Land	202150
Improvements	751750
Total	953900

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) 2019.

DATED this: 7/31/2020

Petitioner's Representative

Gregory L. Korth

Digitally signed by Gregory L. Korth
DN: cn=Gregory L. Korth, o=Adams County, ou=Assessor, email=gkorth@adcogov.org, c=US
Date: 2020.07.30 14:38:07 -06'00'

Assessor Representative
Adams County Assessor's Office

ADAMS COUNTY ASSESSOR'S RECOMMENDATION WORKSHEET
BOARD OF COUNTY COMMISSIONERS (BOCC)

Account No : **R0147811** Parcel No : **0171934121015**
Petition Year : **2019** Petition Filed Date : **June 2, 2020**
Owner Entity : **Soto-Juaquez Cruz**
Owner Address : **5640 E. 64th Avenue**
Owner City : **Commerce City** State : **CO**
Property Location : **7677 Washington Street, Denver, CO 80229**

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	353	L:		L: **$202,150**	**$58,620**	A. Ratio	**29.00%**
		I:		I: **$1,291,638**	**$374,580**	Mill Levy	**100.745**
TOTALS :		**$900,000**	**$261,000**	**$1,493,788**	**$433,200**	Original Tax	**$43,643**

Petitioner's Statement :

Property has been overvalued. The property has no undergone renovations, it is not in newer condition, yet assessor made a change of $822,910 over previous year.

Assessor's Report

Situation :

Appraiser re-valued the property. Market rent and price data metrics indicate that 2019 Adams Actual Value exceeded 2019 Market Value.

Action :

Appraiser determined reasonable 2019 Actual Value to be $953,900.

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		**RECOMMENDED VALUE**		**REVISED TAX WARRANT**	
		Actual Value	Assessed Value	**Actual Value**	**Assessed Value**	Tax Refund	
REAL	353	L: **$202,150**	**$58,620**	L: **$202,150**	**$58,620**		**$15,773.64**
		I: **$1,291,638**	**$374,580**	I: **$751,750**	**$218,010**	Revised Tax	
TOTALS :		**$1,493,788**	**$433,200**	**$953,900**	**$276,630**		**$27,869.09**

Gregory L. Korth — August 3, 2020
Appraiser — Date

118213

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received _____
(Use Assessor's or Commissioners' Date Stamp)

Section I: Petitioner, please complete Section I only.

Date: 5 / 20 / 2020
Month Day Year

Petitioner's Name: Cruz Soto-Jaquez

Petitioner's Mailing Address: 5640 E 64th Ave

Commerce City CO 80022
City or Town State Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
SUB: D AND D BLK: 1 LOT 1	7677 Washington St, Denver, CO 80229
RV1478H	

JUN 02 2020
OFFICE OF THE ADAMS COUNTY ASSESSOR

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

I believe that the property has been overevaluated. The property has not undergone renovations, it is not in newer condition, yet the assesor has made a change of $822,910.00 more than the previous year.

Petitioner's estimate of value: $ 900,000 (2019)
Value Year

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Petitioner's Signature

Daytime Phone Number (720) 767-5943

Email alondra.loya7@gmail.com

By _____
Agent's Signature*

Daytime Phone Number ( )

Email _____

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

Assessor's or Deputy Assessor's Signature

15-DPT-AR No. 920-66/15

FOR ASSESSORS AND COUNTY COMMISSIONERS USE ONLY
(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S.

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____
Petitioner's Signature **Date**

_____ _____
Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on _____/_____/_____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ ***(being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____
Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____
County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____
Secretary's Signature Property Tax Administrator's Signature Date

Ken Musso
Assessor

ADAMS COUNTY
COLORADO

Assessor's Office
4430 South Adams County Parkway
2nd Floor, Suite C2100
Brighton, CO 80601-8201
Phone 720-523-6038
Fax 720-523-6037
www.adcogov.org

BOARD OF COUNTY COMMISSIONERS

STIPULATION (As to Tax Year(s) 2019 Actual Value(s))

1. The property subject to this Stipulation is:
Schedule No. (S): R0175821 Parcel N0.(S) 0157328125006

2. The subject property is classified as a Commercial property.

3. The County Assessor originally assigned the following actual value to the subject property for tax year(s) **2019**:

Land	$1,531,740
Improvements	$1,692,450
Total	$3,224,190

4. The Adams County Assessor has reviewed this file and agrees to make the following adjustment to the valuation for the subject property for tax year(s) **2019**:

Land	$1,531,740
Improvements	$93,260
Total	$1,625,000

5. By entering into this agreement, the Petitioner understands that they are giving up rights to further appeal of the value of this property for tax year(s) **2019**.

DATED this: August 3, 2020

Petitioner's Representative

Shannon C. Wheeler
Digitally signed by Shannon C. Wheeler
DN: cn=Shannon C. Wheeler, o=Adams County Government, ou=Assessor's Office, email=swheeler@adcogov.org, c=US
Date: 2020.08.03 11:03:38 -06'00'

Assessor Representative
Adams County Assessor's Office

ADAMS COUNTY ASSESSOR'S RECOMMENDATION WORKSHEET
BOARD OF COUNTY COMMISSIONERS (BOCC)

Account No : **R0175821** Parcel No : **0157328125006**
Petition Year : **2019** Petition Filed Date : **June 4, 2020**
Owner Entity : **13591 HURON STREET LLC**
Owner Address : **3000 Gulf To Bay Boulevard - STE 303**
Owner City : **Clearwater** State : **FL**
Property Location : **13891 Huron Street - Westminster**

TYPE	OCC CODE	PETITIONER'S REQUESTED VALUES		ASSESSOR'S ASSIGNED VALUES		ORIGINAL TAX WARRANT	
		Actual Value	Assessed Value	Actual Value	Assessed Value		
REAL	353	L:		L: **$1,531,740**	**$444,200**	A. Ratio	**29.00%**
		I:		I: **$1,692,450**	**$490,810**	Mill Levy	**117.548**
TOTALS :		**$1,625,000**	**$471,250**	**$3,224,190**	**$935,010**	Original Tax	**$109,909**

Petitioner's Statement :

Value should be adjusted to the 2020 value.

Assessor's Report

Situation :

Adjusted 2020 ASR as a result of classification and was unable to equalize until abatement was filed.

Action :

Adjusted value to the 2020 valuatuion findings.

Recommendation :

Upon further review, a reduction in value appears warranted.

ASSESSOR'S RECOMMENDED ADJUSTMENT

TYPE	OCC CODE	ASSESSOR'S ASSIGNED VALUE		**RECOMMENDED VALUE**		**REVISED TAX WARRANT**	
		Actual Value	Assessed Value	**Actual Value**	**Assessed Value**	Tax Refund	
REAL	353	L: **$1,531,740**	**$444,200**	L: **$1,531,740**	**$444,200**		**$54,514.06**
		I: **$1,692,450**	**$490,810**	I: **$93,260**	**$27,050**	Revised Tax	
TOTALS :		**$3,224,190**	**$935,010**	**$1,625,000**	**$471,250**		**$55,394.50**

Shannon Wheeler — August 3, 2020
Appraiser — Date

PETITION FOR ABATEMENT OR REFUND OF TAXES

County: Adams

Date Received RECEIVED
(Use Assessor's or Commissioners' Date Stamp)

JUN 04 2020

OFFICE OF THE
ADAMS COUNTY ASSESSOR

Section I: Petitioner, please complete Section I only.

Date: June 4, 2020
Month Day Year

Petitioner's Name: Catalyst Property Tax - Jason Flynn - (720)744-3237 - flynn@catalystpropertytax.com

Petitioner's Mailing Address: 2291 Arapahoe Avenue

Boulder	CO	80302
City or Town	State	Zip Code

SCHEDULE OR PARCEL NUMBER(S)	PROPERTY ADDRESS OR LEGAL DESCRIPTION OF PROPERTY
R0175821	13591 Huron

Petitioner requests an abatement or refund of the appropriate taxes and states that the taxes assessed against the above property for the property tax year 2019 are incorrect for the following reasons: (Briefly describe why the taxes have been levied erroneously or illegally, whether due to erroneous valuation, irregularity in levying, clerical error, or overvaluation. Attach additional sheets if necessary.)

2019 abatement based on erroneous valuation for assessment to match reduction on 2020

Petitioner's estimate of value: $ 1,625,000 (Value) (2019) (Year)

I declare, under penalty of perjury in the second degree, that this petition, together with any accompanying exhibits or statements, has been prepared or examined by me, and to the best of my knowledge, information, and belief, is true, correct, and complete.

Petitioner's Signature — Daytime Phone Number ( )

By Agent's Signature — Daytime Phone Number (720) 744-3237

*Letter of agency must be attached when petition is submitted by an agent.

If the Board of County Commissioners, pursuant to § 39-10-114(1), C.R.S., or the Property Tax Administrator, pursuant to § 39-2-116, C.R.S., denies the petition for refund or abatement of taxes in whole or in part, the Petitioner may appeal to the Board of Assessment Appeals pursuant to the provisions of § 39-2-125, C.R.S., within thirty days of the entry of any such decision, § 39-10-114.5(1), C.R.S.

Section II: **Assessor's Recommendation**
(For Assessor's Use Only)

Tax Year _____

	Actual	Assessed	Tax
Original			
Corrected			
Abate/Refund			

☐ **Assessor recommends approval as outlined above.**

If the request for abatement is based upon the grounds of overvaluation, no abatement or refund of taxes shall be made if an objection or protest to such valuation has been filed and a Notice of Determination has been mailed to the taxpayer, § 39-10-114(1)(a)(I)(D), C.R.S.

Tax year: _____ Protest? ☐ No ☐ Yes (If a protest was filed, please attach a copy of the NOD.)

☐ **Assessor recommends denial for the following reason(s):**

Assessor's or Deputy Assessor's Signature

(Section III or Section IV must be completed)

Every petition for abatement or refund filed pursuant to § 39-10-114, C.R.S. shall be acted upon pursuant to the provisions of this section by the Board of County Commissioners or the Assessor, as appropriate, within six months of the date of filing such petition, § 39-1-113(1.7), C.R.S

Section III: Written Mutual Agreement of Assessor and Petitioner

(Only for abatements up to $10,000)

The Commissioners of _____ County authorize the Assessor by Resolution No. _____ to review petitions for abatement or refund and to settle by written mutual agreement any such petition for abatement or refund in an amount of $10,000 or less per tract, parcel, or lot of land or per schedule of personal property, in accordance with § 39-1-113(1.5), C.R.S.

The Assessor and Petitioner mutually agree to the values and tax abatement/refund of:

Tax Year _____

	Actual	Assessed	Tax
Original	_____	_____	_____
Corrected	_____	_____	_____
Abate/Refund	_____	_____	_____

Note: The total tax amount does not include accrued interest, penalties, and fees associated with late and/or delinquent tax payments, if applicable. Please contact the County Treasurer for full payment information.

_____ _____

Petitioner's Signature **Date**

_____ _____

Assessor's or Deputy Assessor's Signature **Date**

Section IV: Decision of the County Commissioners

(Must be completed if Section III does not apply)

WHEREAS, the County Commissioners of _____ County, State of Colorado, at a duly and lawfully called regular meeting held on ____/____/____, at which meeting there were present the following members:
Month Day Year

_____

_____

with notice of such meeting and an opportunity to be present having been given to the Petitioner and the Assessor of said County and Assessor _____ ***(being present--not present)*** and
Name

Petitioner _____ (***being present--not present)***, and WHEREAS, the said
Name

County Commissioners have carefully considered the within petition, and are fully advised in relation thereto, NOW BE IT RESOLVED that the Board ***(agrees--does not agree)*** with the recommendation of the Assessor, and that the petition be ***(approved--approved in part--denied)*** with an abatement/refund as follows:

Year	Assessed Value	Taxes Abate/Refund
_____	_____	_____

_____

Chairperson of the Board of County Commissioners' Signature

I, _____ County Clerk and Ex-Officio Clerk of the Board of County Commissioners in and for the aforementioned county, do hereby certify that the above and foregoing order is truly copied from the record of the proceedings of the Board of County Commissioners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County this _____ day of _____, _____.
Month Year

_____

County Clerk's or Deputy County Clerk's Signature

Note: Abatements greater than $10,000 per schedule, per year, must be submitted in duplicate to the Property Tax Administrator for review.

Section V: Action of the Property Tax Administrator

(For all abatements greater than $10,000)

The action of the Board of County Commissioners, relative to this petition, is hereby
☐ Approved ☐ Approved in part $_____ ☐ Denied for the following reason(s):

_____ _____ _____

Secretary's Signature Property Tax Administrator's Signature Date

Catalyst Property Tax Consultants LLC
2291 Araphoe Avenue
Boulder, CO 80302
(720)744-3237

FAX

From: Jason Flynn - Catalyst Property Tax
Return Fax: (877)635-0070
Attention To: Adams County Assessor Appeal Sub
Regarding: 2019 abatement on R0175821

I am dropping a copy of this abatement in the mail just in case fax is not acceptable. Thank you.

Jason Flynn
720-744-3237
flynn@catalystpropertytax.com

Catalyst Property Tax Consultants

STATEMENT OF AGENCY

This Agreement made on May 29, 2020, by and between

13591 Huron Street LLC
3000 Gulf to Bay Blvd, Suite 303
Clearwater, FL 33759-4304

(Hereinafter "Taxpayer")

Catalyst Property Tax Consultants, LLC
2291 Arapahoe Avenue
Boulder, CO 80302
Telephone: 720.344.3237
(Hereinafter "Catalyst")

Taxpayer hereby appoints Catalyst as its representative and agent for assessment years 2019-2022 in connection with the valuations for assessment of Taxpayer's real property in Colorado:

13591 Huron Street
Westminster, CO
(Hereinafter "the Property")

Catalyst shall have full authority to:

1. Review all applicable records relating to the valuation for assessment for the Property;
2. Discuss the valuation for assessment of the Property with the County Auditor/Assessor, or any of his representatives, as to the amount of valuation which Catalyst deems appropriate in the circumstances;
3. Accept on behalf of Taxpayer any valuation for assessment; and
4. Pursue any statutory remedies which Taxpayer may possess, before the County Auditor/Assessor, County Board of Equalization, State Assessment Appeals Board, or in binding arbitration, in Taxpayer's name and on Taxpayer's behalf with regard to the Property.

This appointment of agency shall remain in effect until revoked in writing by both parties.

By: _____(Signature)

Alvin Estevez _____(Printed Name)

Date: June 1st, 2020

STATE OF _____ COUNTY OF _____

In_____, on the ____ day of _____, 20___, before me, a Notary Public in and for the above state and county, personally appeared _____, known to me or proved to be the person named in and who executed the foregoing instrument, and being first duly sworn, such person acknowledged that he or she executed said instrument for the purposes therein contained as his or her free and voluntary act and deed.

_____
NOTARY PUBLIC

(SEAL)

My Commission Expires: _____

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: County Board of Equalization Appointment of Hearing Officers
FROM: Meredith P. Van Horn, Assistant Adams County Attorney; **Elizabeth A. Albright, CBOE/Abatement Coordinator**
AGENCY/DEPARTMENT: County Attorney
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoint the following candidate, Michael Krening, as a 2020 CBOE and/or Abatement and/or Property Tax Exemption Hearing Officer.

BACKGROUND:

Annually, the Board of County Commissioners, sitting as the Adams County Board of Equalization, reviews the assessment roll of all taxable real property located in the County as prepared by the Assessor. Authorization under C.R.S. § 39-8-102 allows the appointment of independent hearing officers who are experienced in property valuation to conduct hearings on appeal of these valuations, on behalf of the Board of Equalization. The Hearing Officers then make findings and submit their recommendations to the County Board of Equalization for its final action.

Hearings on real and personal property tax valuation appeals before the County Board of Equalization, must be conducted between September 16th and November 1st for 2020, and their recommendations approved on or before November 10th, pursuant to C.R.S. § 39-8-107(2).

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Assessor's Office

ATTACHED DOCUMENTS:

Resolution
Adams County Purchase of Service Agreement for Board of Equalization Hearing Officer
Resume and/or Application of Hearing Officer Applicant

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:
Cost Center:

	Object Account	**Subledger**	**Amount**
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	**Subledger**	**Amount**
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION APPOINTING HEARING OFFICER TO HEAR APPEALS BEFORE THE ADAMS COUNTY BOARD OF EQUALIZATION

WHEREAS, the Board of County Commissioners, County of Adams, State of Colorado, also comprises the Adams County Board of Equalization; and,

WHEREAS, C.R.S § 39-8-102, authorizes a County Board of Equalization to appoint independent hearing officers who are experienced in property valuation to conduct hearings on behalf of the County Board of Equalization, and to make findings and submit recommendations to the County Board of Equalization for its final action; and,

WHEREAS, Michael Krening has applied, possesses the requisite licenses and/or credentials and should be appointed to act as a hearing officer to conduct hearings pursuant to C.R.S. § 39-8-102 and C.R.S. § 39-3-206.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, when sitting as the Adams County Board of Equalization, that the person identified below, who is experienced in property valuation, is hereby appointed to act as a hearing officer to conduct hearings pursuant to C.R.S. § 39-8-102, and C.R.S. § 39-3-206, and that his compensation shall be set at the rate of $75 per hour, with a 4-hour minimum.

Name	**Address**
Michael Krening	916 Cherokee Street Fort Morgan, CO 80601 Phone: 303-579-6261 Krenings@msn.com

BE IT FURTHER RESOLVED, that the Chair is authorized to sign the Purchase of Service Agreement for the Board of Equalization Hearing Officer, for the above appointed individual.

ADAMS COUNTY, COLORADO
PURCHASE OF SERVICE AGREEMENT FOR BOARD OF EQUALIZATION HEARING OFFICER

THIS AGREEMENT ("Agreement") is made this 8th day of August 2020, by and between the Adams County Board of County Commissioners, located at 4430 S. Adams County Parkway, Brighton, Colorado 80601, hereinafter referred to as the "County," and Michael Krening, whose address is 916 Cherokee Street, Fort Morgan, CO 80701, hereinafter referred to as the "Contractor." The County and the Contractor may be collectively referred to herein as the "Parties."

The County and the Contractor, for the consideration herein set forth, agree as follows:

1. **SERVICES OF THE CONTRACTOR:**

Contractor shall act as a hearing officer to hear taxpayer appeals of property valuations. Contractor shall enter its findings and ruling into the County's computer system on the day of the appeal in order for the County to send timely notices to the taxpayers.

2. **RESPONSIBILITIES OF THE COUNTY:**

The County shall provide information as necessary or requested by the Contractor to enable the Contractor's performance under this Agreement. County shall provide necessary computer equipment.

3. **TERM:**

Term of Agreement: The term of this agreement shall be for year 2020 and renewable for up to 5 (five) one-year commitments, upon mutual consent of the parties.

4. **PAYMENT AND FEE SCHEDULE:**

The County shall pay the Contractor for services furnished under this Agreement, and the Contractor shall accept as full payment for those services, the sum of $75.00 (Seventy-Five Dollars) per hour with a 4 (four) hour minimum, to be paid within thirty days of the date the work is completed.

5. **INDEPENDENT CONTRACTOR:**

In providing services under this Agreement, the Contractor acts as an independent contractor and not as an employee of the County. The Contractor shall be solely and entirely responsible for his/her acts, and the acts of his/her employees, agents, servants, and subcontractors during the term and performance of this Agreement. No employee, agent, servant, or subcontractor of the Contractor shall be deemed to be an employee, agent, or servant of the County because of the performance of any services or work

under this Agreement. The Contractor, at its expense, shall procure and maintain workers' compensation insurance as required by law. **Pursuant to the Workers' Compensation Act § 8-40-202(2)(b)(IV), C.R.S., as amended, the Contractor understands that it and its employees and servants are not entitled to workers' compensation benefits from the County. The Contractor further understands that it is solely obligated for the payment of federal and state income tax on any moneys earned pursuant to this Agreement.**

6. NONDISCRIMINATION:

The Contractor shall not discriminate against any employee or qualified applicant for employment because of age, race, color, religion, marital status, disability, sex, or national origin. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices provided by the local public agency setting forth the provisions of this nondiscrimination clause.

7. INDEMNIFICATION:

The Contractor agrees to indemnify and hold harmless the County, its officers, agents, and employees for, from, and against any and all claims, suits, expenses, damages, or other liabilities, including reasonable attorney fees and court costs, arising out of damage or injury to persons, entities, or property, caused or sustained by any person(s) as a result of the Contractor's performance or failure to perform pursuant to the terms of this Agreement or as a result of any subcontractors' performance or failure to perform pursuant to the terms of this Agreement.

8. TERMINATION:

8.1. For Cause: If, through any cause, the Contractor fails to fulfill its obligations under this Agreement in a timely and proper manner, or if the Contractor violates any of the covenants, conditions, or stipulations of this Agreement, the County shall thereupon have the right to immediately terminate this Agreement, upon giving written notice to the Contractor of such termination and specifying the effective date thereof.

8.2. For Convenience: The County may terminate this Agreement at any time by giving written notice as specified herein to the other party. If this Agreement is terminated by the County, the Contractor will be paid an amount that bears the same ratio to the total compensation as the services actually performed bear to the total services the Contractor was to perform under this Agreement, less payments previously made to the Contractor under this Agreement.

9. MUTUAL UNDERSTANDINGS:

9.1. Jurisdiction and Venue: The laws of the State of Colorado shall govern as to the

interpretation, validity, and effect of this Agreement. The parties agree that jurisdiction and venue for any disputes arising under this Agreement shall be Adams County, Colorado.

9.2. Compliance with Laws: During the performance of this Agreement, the Contractor agrees to strictly adhere to all applicable federal, state, and local laws, rules and regulations, including all licensing and permit requirements. The parties hereto aver that they are familiar with § 18-8-301, et seq., C.R.S. (Bribery and Corrupt Influences), as amended, and § 18-8-401, et seq., C.R.S. (Abuse of Public Office), as amended, and that no violation of such provisions are present. Without limiting the generality of the foregoing, the Contractor expressly agrees to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when exposed to or provided with any data or records under this Agreement that are considered to be "Protected Health Information."

9.3. OSHA: Contractor shall comply with the requirements of the Occupational Safety and Health Act (OSHA) and shall review and comply with the County's safety regulations while on any County property. Failure to comply with any applicable federal, state or local law, rule, or regulation shall give the County the right to terminate this agreement for cause.

9.4. Record Retention: The Contractor shall maintain records and documentation of the services provided under this Agreement, including fiscal records, and shall retain the records for a period of three (3) years from the date this Agreement is terminated. Said records and documents shall be subject at all reasonable times to inspection, review, or audit by authorized federal, state, or County personnel.

9.5. Assignability: Neither this Agreement, nor any rights hereunder, in whole or in part, shall be assignable or otherwise transferable by the Contractor without the prior written consent of the County.

9.6. Waiver: Waiver of strict performance or the breach of any provision of this Agreement shall not be deemed a waiver, nor shall it prejudice the waiving party's right to require strict performance of the same provision, or any other provision in the future, unless such waiver has rendered future performance commercially impossible.

9.7. Force Majeure: Neither party shall be liable for any delay or failure to perform its obligations hereunder to the extent that such delay or failure is caused by a force or event beyond the control of such party including, without limitation, war, embargoes, strikes, governmental restrictions, riots, fires, floods, earthquakes, or other acts of God.

9.8. Notice: Any notices given under this Agreement are deemed to have been

received and to be effective: (1) three (3) days after the same shall have been mailed by certified mail, return receipt requested; (2) immediately upon hand delivery; or (3) immediately upon receipt of confirmation that a facsimile was received. For the purposes of this Agreement, any and all notices shall be addressed to the contacts listed below:

Adams County Attorney's Office 4430 S. Adams County Parkway 5th Floor, Suite C5000B Brighton, Colorado 80601 Phone: 720-523-6116 Fax: 720-523-6114
Adams County Board of Equalization Contact: Elizabeth A. Albright Address: 4430 S. Adams County Parkway, 5th Floor, Suite C5000B Brighton, Colorado 80601 Phone: 720-523-6328 Fax: 720-523-6114 Email: balbright@adcogov.org
Michael Kening 916 Cherokee Street Fort Morgan, CO 80601 Phone: 303-579-6261 Krenings@msn.com

9.9. Integration of Understanding: This Agreement contains the entire understanding of the parties hereto and neither it, nor the rights and obligations hereunder, may be changed, modified, or waived except by an instrument in writing that is signed by the parties hereto.

9.10. Severability: If any provision of this Agreement is determined to be unenforceable or invalid for any reason, the remainder of this Agreement shall remain in effect, unless otherwise terminated in accordance with the terms contained herein.

9.11. Authorization: Each party represents and warrants that it has the power and ability to enter into this Agreement, to grant the rights granted herein, and to perform the duties and obligations herein described.

10. COMPLIANCE WITH C.R.S. § 8-17.5-101, ET. SEQ. AS AMENDED 5/13/08: Pursuant to Colorado Revised Statute (C.R.S.), § 8-17.5-101, *et. seq.*, as amended 5/13/08, the Contractor shall meet the following requirements prior to signing this Agreement (public contract for service) and for the duration thereof:

10.1. The Contractor shall certify participation in the E-Verify Program (the electronic employment verification program that is authorized in 8 U.S.C. § 1324a and jointly administered by the United States Department of Homeland Security and the Social Security Administration, or its successor program) or the Department Program (the employment verification program established by the Colorado Department of Labor and Employment pursuant to C.R.S. § 8-17.5-102(5)) on the attached certification.

10.2. The Contractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

10.3. The Contractor shall not enter into a contract with a subcontractor that fails to certify to the Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

10.4. At the time of signing this public contract for services, the Contractor has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this public contract for services through participation in either the E-Verify Program or the Department Program.

10.5. The Contractor shall not use either the E-Verify Program or the Department Program procedures to undertake pre-employment screening of job applicants while this public contract for services is being performed.

10.6. If Contractor obtains actual knowledge that a subcontractor performing work under this public contract for services knowingly employs or contracts with an illegal alien, the Contractor shall: notify the subcontractor and the County within three days that the Contractor has actual knowledge that the subcontractor is employing or contracting with an illegal alien; and terminate the subcontract with the subcontractor if within three days of receiving the notice required pursuant to the previous paragraph, the subcontractor does not stop employing or contracting with the illegal alien; except that the contractor shall not terminate the contract with the subcontractor if during such three days the subcontractor provides information to establish that the subcontractor has not knowingly employed or contracted with an illegal alien.

10.7. Contractor shall comply with any reasonable requests by the Department of Labor and Employment (the Department) made in the course of an investigation that the Department is undertaking pursuant to the authority established in C.R.S. § 8-17.5-102(5).

10.8. If Contractor violates this Section, of this Agreement, the County may terminate this Agreement for breach of contract. If the Agreement is so terminated, the Contractor shall be liable for actual and consequential damages to the County.

LAWFUL PRESENCE AFFIDAVIT

I, Michael L. Krening, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

✓ I am a United States Citizen, or

____ I am a legal Permanent Resident of the United States, or

____ I am otherwise lawfully present in the United States pursuant to Federal law

(note: additional verification will be required through the "SAVE" program*).

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Michael L Krening
Signature

8/11/20
Date

COUNTY USE ONLY

Identification Produced (check one):

_____ Colorado Drivers License

_____ Colorado Identification Card

_____ United States Military Card

_____ United States Military Dependent's Card

_____ United States Coast Guard Merchant Mariner Card

_____ Native American Tribal Document

_____ *Verification to be completed through the "SAVE" program.

Identification produced to: _____, of Adams County. _____

Name of county employee Initials

IN WITNESS WHEREOF, the Parties have caused their names to be affixed hereto.

Adams County Board of Equalization _____ Emma Pinter	_____ Date:
Approved as to Form _____ Meredith P. VanHorn Assistant County Attorney Adams County Attorney's Office	_____ Date:
Signature: Michael L Krening Name: Michael L. Krening	_____ Date: 8/12/20

COUNTY OF ADAMS)
)ss
STATE OF COLORADO)

Signed and sworn to before me this 12th day of August, 2020 by Michael Krening.

SUSAN L. WESTHOFF
Notary Public
State of Colorado
Notary ID # 20084033022
My Commission Expires 09-22-2020

Susan L. Westhoff
Notary Public

My commission expires on: 9/22/2020

QUALIFICATION OF APPRAISER

Name: **Michael L. Krening**
916 Cherokee Street
Fort Morgan, Colorado 80701

Licensing: **Certified General Appraiser, which legally allows appraisal of all types of Real Estate in the State of Colorado, including Industrial, Commercial, Agricultural, and Residential.**
State License #CG01318281

Education: **Graduate - Fort Morgan High School**

State of Colorado Appraisal Courses:

- Introduction to Assessment
-Appraisal 101 (Cost Approach)
-Appraisal 102 (Market Approach)
-Appraisal 103 (Income Approach)
-Appraisal 201 (Personal Property)
-Appraisal 584 (CAMA/MRA)
-Appraisal 215 (CATA)
-Appraisal 030 (EPA)
-Appraisal 450 (Oil and Gas Netback)
-Appraisal 458 (Gas Plant Valuation)
-Appraisal 310 (Valuation Performance Analysis)
-Appraisal 401 (Agricultural Land)
-Appraisal 583 (Time Trend Analysis)
-Conservation Easements
-Business Valuation
-Golf Course Valuation
-Severed Minerals
-Ag Land/Elevator School
-Depreciation Workshop
-Land Classification Workshop
-Sales Confirmation/Time Adjustment Workshop
-Vacant Land Discounting Workshop
-Court Decisions Workshop
-Hazardous Waste Workshop
-Standards and Ethics Workshop
-Valuation of Rural Structures
-Environmental Contaminated Properties
-Time Trending
-Vacant Land Valuation

-Colorado Water Law
-Agricultural Land Valuation
-Financing and Time Adjustments
-Real Estate Court Decisions
-Contaminated Properties

State Classes Cont.

-Assessment Appeals Process
-Presenting Your Best Case
-Manufactured Homes Workshop
-Possessory Interest
-Ownership, Legal Description & Mapping
- Hotel/Motel Workshop
-Abatement's
- Valuation of Rural Structures
- Uniform Practice of Professional Practice

IAAO Appraisal Courses:

-Course 1 - Fundamentals of Property Appraisal
-Course 2 - Income Approach to Value
-Course 201 - Appraisal of Land
-Course 207 - Industrial Property Appraisal
-Multiple Regression Analysis
-Capitalization Workshop
-Standards of Practice and Professional Ethics
-Contemporary Capitalization Techniques Workshop
-Developing Capitalization Rates
-Valuation of Commercial Retail Properties
- Marshall & Swift Valuation Seminar
-937 House Construction Design & Systems

Other Vendors

-Narrative Report Writing
-Hotel Motel Valuation
-Understanding Owner Occupied Properties
-Property Design and Measurement
-Rate Development
-Appraisal Valuation Modeling
-Restructuring Income and Expense Statements
-Colorado Water Law I
-Colorado Water Law II

-Logic & Critical Thinking of Appraising
-Intro to Commercial Appraisal
-Automated Valuation Modeling
-Going Concern Valuation
-Income Approach Applications

Employment:

Retail Sales - Nine years
Construction - Four years
Residential Appraiser, Morgan County - 1985-1988
Commercial Appraiser, Morgan County – 1988 Retired Jan. 2020
Chief Appraiser, Morgan County 1988-1989
Deputy Assessor, Chief Commercial Appraiser
Morgan County – 1989- Retired Jan. 2020

Affiliations:

International Association of Assessing Officers
Member - 1993-2020
Colorado Association of Tax Appraisers
Member - 1988-2020

Other:

I have attended many Assessors Law Seminars, Summer and Winter Conferences presented by The Division of Property Tax since 1989.

I was in sole charge of completing all modeling and valuation of Commercial / Industrial properties, including interaction with the State Auditor for the Property Assessment Study since 1989. No Audit recommendations have been issued. I have met the requirement set forth by the State of Colorado for statistical requirements. Morgan County's Commercial / Industrial classification currently represents over 40% of the assessed value performed by the real property appraisers in Morgan County. This information is available upon request.

I have done narrative appraisals on commercial and special purpose properties such as, car-washes, motels, banks, service stations, grocery stores, meat packing facilities, drive-in theaters, etc. as well as appraisals on residential properties, since 1988.

I have been seated as an Expert Witness in both, Boards of Assessment Appeals Hearings as well as for testimony concerning valuation in Court in Morgan County, for matters of private litigation.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Resolution approving right-of-way agreement between Adams County and Clear Creek Station Metropolitan District No. 1 for property necessary for the Traffic Signal Cabinet Upgrade Project
FROM: Kristin Sullivan, AICP, Director of Public Works Brian Staley, P.E., PTOE, Deputy Director of Public Works
AGENCY/DEPARTMENT: Public Works
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves the right-of-way agreement for acquisition of property interests needed for the Traffic Signal Cabinet Upgrade Project

BACKGROUND:

Adams County is in the process of acquiring property interests throughout unincorporated Adams County for upgrades to existing traffic signal cabinets. The intention of this Project is to identify and improve the traffic signal cabinets at intersections. Attached is a copy of the right-of-way agreement between Adams County and Clear Creek Station Metropolitan District No. 1 for acquisition of property interests in the amount of $6,345.00. The attached resolution allows the County to acquire ownership of the property interests needed for the use of the public and provide the necessary documents to close on the property.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Public Works, Office of the County Attorney and Adams County Board of County Commissioners.

ATTACHED DOCUMENTS:

Draft resolution
Right-of-way agreement

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 13
Cost Center: 3056

	Object Account	**Subledger**	**Amount**
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	**Subledger**	**Amount**
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:	9135	30562001	$10,000,000
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			**$10,000,000**

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING RIGHT-OF-WAY AGREEMENT BETWEEN ADAMS COUNTY AND CLEAR CREEK STATION METROPOLITAN DISTRICT NO. 1 FOR PROPERTY NECESSARY FOR THE TRAFFIC SIGNAL CABINET UPGRADE PROJECT

WHEREAS, Adams County is in the process of acquiring right-of-way and easements at several intersections throughout the County for the Traffic Signal Cabinet Upgrade Project ("Project"); and,

WHEREAS, the intention of the Project is to identify and replace outdated traffic signal cabinets ("Improvements"); and,

WHEREAS, this easement acquisition is a portion of 1625 West 67th Avenue and 1610 ½ West 67th Avenue located in the Southwest Quarter of Section 4, Township 3 South, Range 68 West of the 6th Principal Meridian, County of Adams, State of Colorado, and owned by Clear Creek Station Metropolitan District No. 1 ("Parcel 5 and 6"); and,

WHEREAS, Adams County requires ownership of Parcel 5 and 6 for construction of the Improvements; and,

WHEREAS, Clear Creek Station Metropolitan District No. 1 is willing to sell Parcel 5 and 6 to Adams County under the terms and conditions of the attached Right-of-Way Agreement.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the Right-of-Way Agreement between Adams County and Clear Creek Station Metropolitan District No. 1, a copy of which is attached hereto and incorporated herein by this reference, be and hereby is approved.

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

Right-of-Way Agreement

This Agreement is made and entered into by and between **CLEAR CREEK STATION METROPOLITAN DISTRICT NO. 1,** whose address is **11002 Benton Street, Westminster, CO, 80020** ("Owner"), and the County of Adams, State of Colorado, a body politic, who address is 4430 South Adams County Parkway, Brighton, Colorado, 80601 ("County") for the conveyance of rights-of-way on property located at 1625 West 67th Avenue and 1610 ½ West 67th Avenue being conveyed hereinafter (the "Property") for the Traffic Signal Cabinet Upgrade Project (the "Project"). The legal description and conveyance documents for the interests on said Property are set forth in Exhibit A, B, C & D attached hereto and incorporated herein by this reference.

The compensation agreed to by the Owner and the County for the acquisition of the Property interests described herein is **SIX THOUSAND THREE HUNDRED FORTY-FIVE AND NO/100 DOLLARS ($6,345.00),** including the performance of the terms of this Agreement, the sufficiency of which is hereby acknowledged. The parties further agree that the consideration shall consist of $6,345.00 for the conveyance of permanent utility easements. This consideration has been agreed upon and between the parties as the total just compensation due to the Owner and the consideration shall be given and accepted in full satisfaction of this Agreement.

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

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

2. The Owner agrees to execute and deliver to the County the attached conveyance documents on the property upon tender by the County of a warrant (check) for the compensation agreed upon as soon as possible following the execution of this agreement.

3. The Owner hereby irrevocably grants to the County possession and use of the property interests on the Property upon execution of this Agreement by the Owner and the County. This grant of possession shall remain in effect with respect to the Property until such time as the County obtains from the Owner the attached conveyance documents.

4. The Owner agrees to pay all 2019 taxes due in 2020 prior to tender by the County.

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

6. In further consideration of the granting of this easement, it is hereby agreed that all work performed by the County, its successors, and assigns, in connection with this easement shall be done with care. Following completion of the work performed the surface of the property disturbed during construction shall be restored reasonably similar to its original condition, or as close thereto as possible, except as necessarily modified to accommodate the street improvements being installed.

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

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

9. This Agreement contains all agreements, understandings and promises between the Owner and the County, relating to the Project and shall be deemed a contact binding upon the Owner and County and extending to the successors, heirs and assigns.

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

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

Clear Creek Station Metropolitan District No. 1:

By: _____

Print: Rachel Williams, President

Date: 8/11/20

Approved:

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

_____ _____

Chair Date

Approved as to Form:

_____

County Attorney

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 18, 2019
SUBJECT: Adams County's Scientific and Cultural Facilities District Funding Distribution Plan
FROM: Byron Fanning, Director, Zoe Ocampo, Cultural Arts Liaison
AGENCY/DEPARTMENT: Parks, Open Space and Cultural Arts
HEARD AT STUDY SESSION ON August 04, 2020
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves Adams County's Scientific and Cultural Facilities District Funding Distribution for 2020/2021

BACKGROUND:

SCFD has distributed funds from a 1/10 of 1% sales and use tax to qualified cultural organizations throughout the seven-county Denver, Colorado metropolitan area. The funds support cultural facilities whose primary purpose is to enlighten and entertain the public through the production, presentation, exhibition, advancement and preservation of art, music, theatre, dance, zoology, botany, natural history and cultural history.

The Adams County Cultural Council evaluates qualified organizations each year to provide the recommendations to the Board of County Commissioners on how to distribute the 2020-2021 SCFD allocation. The SCFD district board provided Adams County with $1,356,701.11 for the 2020-20 21 funding allocation. ACCC provided funding to 106 projects, 3 visual art projects, and 19 general operating support organizations within Adams County.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Cultural Council

Parks, Open Space and Cultural Arts

ATTACHED DOCUMENTS:

Resolution
Adams County's Scientific and Cultural Facilities District Funding Distribution Plan for 2019/2020
Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

SCFD provides all the funding through the 1/10 of 1% sales tax revenue each year.

RESOLUTION APPROVING ADAMS COUNTY SCIENTIFIC AND CULTURAL FACILITIES DISTRICT FUNDING DISTRIBUTION PLAN FOR 2020-2021

Resolution 2020

WHEREAS, $1,356,701.11 is currently available from the Scientific and Cultural Facilities District tax for distribution to qualified organizations in Adams County; and,

WHEREAS, the Adams County Cultural Council solicited applications for said funds; and,

WHEREAS, after careful review of those applications, the Adams County Cultural Council has made recommendations to the Board of County Commissioners for distribution of $1,356,701.11.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the recommendations on the Adams County Cultural Council's Funding Plan, which are attached hereto and incorporated herein, are hereby approved and adopted.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners is hereby authorized to approve the distribution of funds to the qualified organizations on behalf of Adams County.

SCFD Funding Recommendation 2020-2021

Adams County Cultural Council
and
Parks, Open Space and Cultural Arts

ADAMS COUNTY
COLORADO

2020-2021 SCFD Funding Allocation

- $1,356,701.11 allocated for Adams County
  - $400,781 decrease from last year

- 110 projects submitted by 79 organizations
- 3 Visual Arts projects submitted
- 19 Organizations for General Operating Support

ADAMS COUNTY
COLORADO

2019 vs. 2020 SCFD Funding Allocation

	2019	2020
SCFD Total – Adams County	$1,765,108.00	$1,356,701.11
Total Request Dollars	$ 2,029,266.00	$ 2,209,847.00
GAP	$ 264,158.00	$ 853,145.89

ADAMS COUNTY
COLORADO

General Operating Support

- 19 GOS request – Adams County-based
- Funding guidelines – 12.5% funding awarded based on amount raised

•A Child's Song
•Adams County Historical Society
•Adams County Visual Arts Commission
•Brightonmusic Choir and Orchestra
•Colorado Educational Theatre
•Commerce City Cultural Council
•Inside the Orchestra
•Kim Robards Dance
•Life/Art Dance Ensemble
•Northglenn Arts and Humanities
•Northland Fine Arts
•Paletteers Art Club
•Platte Valley Players
•Skyline Chapter, Sweet Adeline's International
•Thornton Arts, Sciences and Humanities
•Thornton Community Band
•Thornton Community Chorus
•Westminster Area Historical and Museum Society
•Westminster Community Artist Series

- Total amount awarded to GOS $209,885.18

ADAMS COUNTY
COLORADO

Visual Arts Projects

- 3 project requests - Adams County Only
- Funding guidelines – 100% of request
  - Brighton Cultural Arts Commission, $28,466.00
    - Sculpture Walk/Art on Loan
  - Northglenn Arts & Humanities Foundation, $23,500.00
    - Northglenn Art on Parade
  - Thornton Arts, Science and Humanities, $27,521.17
    - Outside the Box: Traffic Mural Project
- Total amount awarded to Visual Art
  - $79,487.17

ADAMS COUNTY
COLORADO

Small Projects

- 27 small project requests
- Funding recommendations
  - Superior, 96%, 7 projects
  - Excellent, 91%, 9 projects
  - Good, 85%, 6 projects
  - No fund, 3 projects
    - Chamber Music Society of Boulder
    - Westminster Area Historical Society & Museums (2 projects)

Total amount awarded to Small Programs

- $74,320.01

ADAMS COUNTY
COLORADO

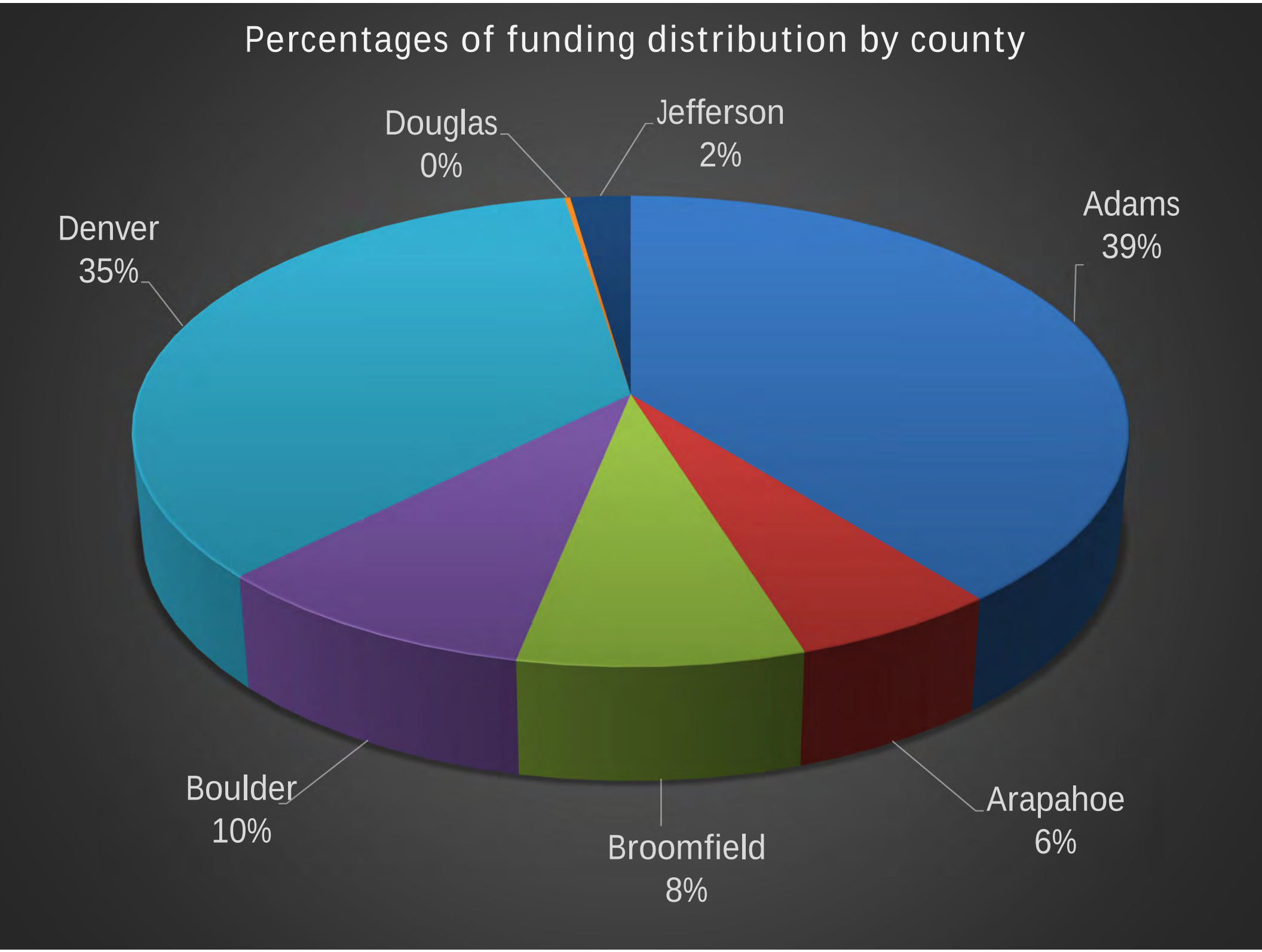
Large Projects

- 83 project requests
- Funding recommendations
  - Superior, 65%, 10 projects
  - Excellent, 60%, 26 projects
  - Enterprising, 55%, 21 projects
  - Good, 50%, 24 projects
  - Not funded, 2 projects
    - Levitt Pavilion
    - Curious Theatre Company

Total amount awarded to Large Projects

•$993,008.75

ADAMS COUNTY
COLORADO


Percentages of funding distribution by county
Douglas
0%
Jefferson
2%
Adams
39%
Denver
35%
Boulder
10%
Broomfield
8%
Arapahoe
6%

Staff and Council Recommendation

GOS	$209,885.18
Visual Arts	$79,487.17
Small project	$74,320.01
Large project	$993,008.75
Total	$1,356,701.11

Carry over $2.99 for 2021-22

ADAMS COUNTY
COLORADO

Questions

ADAMS COUNTY
COLORADO

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: 2020 Delta Dental Benefits Contracts
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: October 15, 2019
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approves the 2020 Delta Dental of Colorado Benefits Contracts.

BACKGROUND: The Adams County Board of County Commissioners previously entered into a contract with Delta Dental of Colorado to provide Third Party Administration for the county's self-funded dental plan through the Delta Dental Premier Provider Option ("Premier") and a fully-insured dental plan through the Delta Dental Exclusive Panel Option ("EPO") for current employees, and continued dental coverage for eligible retirees through the Delta Dental Preferred Provider Option ("PPO") Plan.

The attached appendices outline the change in funding arrangement for the Delta Dental Exclusive Panel Option ("EPO") plan, the addition of the Prevention First Benefit, and changes to the administrative fees and premiums for the 2020 contracts with Delta Dental of Colorado as approved through Study Session.

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

ATTACHED DOCUMENTS:
2020 Amendment to Group Agreement – PPO Plan Contract ADCO
2020 Amendment to Group Agreement – EPO Plan Contract ADCO
2020 Amendment to Group Agreement – PPO Plan Contract ADCO Retiree
2020 Delta Dental PPO Plan Schedule of Benefits ADCO
2020 Delta Dental EPO Plan Schedule of Benefits ADCO
2020 Delta Dental PPO Plan Schedule of Benefits ADCO Retiree

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8614

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION TO ADOPT DELTA DENTAL BENEFITS CONTRACTS

WHEREAS, the Board of County Commissioners recognizes the importance of continuing to provide choice in dental plan options for active and retired employees; and,

WHEREAS, the Adams County Board of County Commissioners previously entered into a contract with Delta Dental of Colorado to provide Third Party Administration for the county's self-funded dental plan through the Delta Dental Premier Provider Option ("Premier") and a fully-insured dental plan through the Delta Dental Exclusive Panel Option ("EPO") for current employees, and continued dental coverage for eligible retirees through the Delta Dental Preferred Provider Option ("PPO") Plan (collectively, the "Delta Dental Benefits Contracts"); and,

WHEREAS, the funding arrangement with Delta Dental of Colorado for the Delta Dental Exclusive Panel Option ("EPO") is transitioned from a fully-insured to a self-funded arrangement as approved through study session; and,

WHEREAS, the attached appendices outline the changes to the eligibility; addition of the Prevention First Benefit; and changes to the administrative fees and premiums with Delta Dental of Colorado in effect through December 31, 2020.

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Delta Dental Benefits Contracts effective January 1, 2020.

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

DELTA DENTAL

DELTA DENTAL OF COLORADO
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are ADAMS COUNTY GOVERNMENT (EPO SCHEDULE 1B), herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental."

The following sections of the current Delta Dental EPO contract has been amended effective January 1, 2020 for a one year period. The balance of such contract is continued as if fully set forth herein except for the amended section as shown below:

Rate Coverage

Composite	Admin Fee
PER MONTH PER SUBSCRIBER	$ 3.80

This Service Fee is contingent upon total enrollment of all eligible primary subscribers, in accordance with the eligibility provisions in Article III. Should enrollment vary by 10% or more, Delta Dental reserves the right to recalculate the Service Fee based upon actual enrollment. The change in Service Fee would not become effective until the next contract anniversary. If a recalculation becomes necessary, multiple-year contracts will be replaced with a new agreement based upon the new enrollment.

The Service is due the first day of each month, and as further described in Article II. The Monthly Claims Reimbursement Due Date is the 2nd, 12th, and 22nd day or the last business day closest to such date of each month and as further described in Article II.

Eligibility Waiting Period:
Active employees working the minimum number of hours as required by the employer will become eligible for enrollment on the first day of the month coinciding with or following their date of employment.

Countersigned:
Delta Dental of Colorado

Mark Thompson

Signature

June 8, 2020

Date

Accepted:
Adams County Government (EPO Schedule 1B) - # 7195 & 97195

_____

Signature

_____

Date

APPROVED AS TO FORM
COUNTY ATTORNEY

DELTA DENTAL OF COLORADO
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are ADAMS COUNTY COLORQADO- RETIREES, herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental."

The following section of the current Delta Dental PPO contract has been amended effective January 1, 2020 for a one year period. The balance of such contract is continued as if fully set forth herein except for the change as shown below.

Rate Coverage

Coverage Tier	Rate Amount
SUBSCRIBER	$ 42.99
SUBSCRIBER PLUS ONE	$ 86.31
SUBSCRIBER PLUS TWO OR MORE DEPENDENTS	$ 129.04

The following section of the current Delta Dental PPO contract has been amended effective January 1, 2020. The balance of such contract is continued as if fully set forth herein except for the changes as shown below.

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P	Individual coverage amount	PPO and Non-PPO	$2000

DELTA DENTAL®

Countersigned:
Delta Dental of Colorado

Mark Thompson

Signature

June 30, 2020

Date

Accepted:
Adams County Colorado-Retirees #7738

Signature

Date

APPROVED AS TO FORM
COUNTY ATTORNEY

DELTA DENTAL

DELTA DENTAL OF COLORADO
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are ADAMS COUNTY GOVERNMENT, herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental."

The following sections of the current Delta Dental PPO contract has been amended effective January 1, 2020 for a one year period. The balance of such contract is continued as if fully set forth herein except for the amended section as shown below:

Rate Coverage

Composite	Admin Fee
PER MONTH PER SUBSCRIBER	$ 3.80

This Service Fee is contingent upon total enrollment of all eligible primary subscribers, in accordance with the eligibility provisions in Article III. Should enrollment vary by 10% or more, Delta Dental reserves the right to recalculate the Service Fee based upon actual enrollment. The change in Service Fee would not become effective until the next contract anniversary. If a recalculation becomes necessary, multiple-year contracts will be replaced with a new agreement based upon the new enrollment.

The Service is due the first day of each month, and as further described in Article II. The Monthly Claims Reimbursement Due Date is the 2nd, 12th, and 22nd day or the last business day closest to such date of each month and as further described in Article II.

The following sections of the current Delta Dental PPO contract has been amended effective January 1, 2020. The balance of such contract is continued as if fully set forth herein except for the amended sections as shown below:

Eligibility Waiting Period:
Active employees working the minimum number of hours as required by the employer will become eligible for enrollment on the first day of the month coinciding with or following their date of employment.

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO and Non-PPO	$2000

DELTA DENTAL®

Countersigned:
Delta Dental of Colorado

Mark Thompson

Signature

June 8, 2020

Date

Accepted:
Adams County Government- # 1200 & 91200

Signature

Date

APPROVED AS TO FORM
COUNTY ATTORNEY

Exclusive Panel Option (EPO)

A feature of the Delta Dental PPO

Adams County Colorado
Group #7195 & 97195
Revised: January 1, 2020

Delta Dental PPO, Exclusive Panel Option (EPO)
Schedule of Benefits
For Group #7195 & 97195
ADAMS COUNTY GOVERNMENT

This Schedule of Benefits should be read in conjunction with your Subscriber Benefit Booklet. Your Subscriber Benefit Booklet will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **Services must be provided by a Delta Dental PPO Provider. In the event services are provided by a non-PPO Provider you will be responsible for all charges incurred.**

Control Plan - Delta Dental of Colorado
Benefit Year - January 1st to December 31st

	PPO Provider
Covered Services	**Co-Payments**
Diagnostic & Preventive Services	
Oral Exams and Cleanings	**Co-Payment is based on Appendix A – Patient Co-Payments 1B**
X-Rays	
Sealants	
Fluoride Treatments	
Basic Services	
Basic Restorative (Fillings)	**Co-Payment is based on Appendix A – Patient Co-Payments 1B**
Oral Surgery	
Endodontics (Root Canal Therapy)	
Periodontics (Gum Disease Treatment)	
Major Services	
Special Restorative (Crowns, Onlays)	**Co-Payment is based on Appendix A – Patient Co-Payments 1B**
Prosthodontics (Dentures, Bridges)	
Orthodontic Services	
Orthodontics	**Co-Payment is based on Appendix A – Patient Co-Payments 1B**

The orthodontic age limitations are hereby waived for the eligible Subscriber, their spouse and dependent children to age 26.

***Services provided by a non-PPO Provider are not a covered benefit and you will be responsible for all charges incurred.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month

Also eligible at your option are your spouse and/or spouse's dependent children to the end of the month in which they turn the dependent age shown above.

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Subscribers may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date.

Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent. The term spouse includes a Civil Union Partner or a Domestic Partner.

Under the Delta Dental EPO plan, all services must be provided a Colorado PPO Participating Provider. In the event services are provided by a non-PPO Participating Provider, the subscriber or dependent will be responsible for all charges incurred.

- You are only responsible for the Co-Payment amount listed on the Co-Payment Appendix sheet for Covered Services.
- Claim forms are submitted directly to Delta Dental by the Providers.
- No balance billing.
- Payment is made directly to the Provider.

No Payment will be made for Services provided by a Provider who is not a Colorado PPO Provider, except for out of state emergency services.

Colorado counties without PPO Providers are Cheyenne, Crowley, Gilpin, Jackson, Kiowa, Saguache, San Juan, and Sedgwick.

DELTA DENTAL

Delta Dental of Colorado
Exclusive Panel Option (EPO)

2020 Schedule EPO 1B
List of Patient Copayments

*See Special Provisions on Last Page

Proc Code	Procedure Code Definition	Patient Copay
DIAGNOSTIC CODES		
D0120	Periodic oral evaluation	$10.00
D0140	Limited oral evaluation - problem focused	$10.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$10.00
D0150	Comprehensive oral evaluation - new or established patient	$10.00
D0160	Detailed and extensive oral evaluation-problem focused, by report	$10.00
D0180	Comprehensive periodontal evaluation - new or established patient	$10.00
D0210	Intraoral-complete series (including bitewings)	$0.00
D0220	Intraoral-periapical-first film	$0.00
D0230	Intraoral-periapical-each additional film	$0.00
D0240	Intraoral-occlusal film	$0.00
D0270	Bitewing-single film	$0.00
D0272	Bitewings-two films	$0.00
D0273	Bitewings-three films	$0.00
D0274	Bitewings-four films	$0.00
D0277	Vertical bitewings-7 to 8 films	$0.00
D0330	Panoramic film	$0.00
D0460	Pulp vitality tests	$0.00
PREVENTIVE CODES		
D1110	Prophylaxis-adult	$0.00
D1120	Prophylaxis-child	$0.00
D1206	Topical Fluoride Varnish - therapeutic application for moderate to high caries risk patients	$0.00
D1208	Topical application of Fuoride - excluding varnish	$0.00
D1351	Sealant-per tooth	$0.00
D1352	Preventive Resin restoration in moderate to high caries risk patient - permanent tooth	$0.00
D1353	Sealant Repair - Per tooth	$0.00
D1510	Space maintainer-fixed-unilateral	$0.00
D1516	Space maintainer-fixed-bilateral, maxillary	$0.00
D1517	Space maintainer-fixed-bilateral, mandibular	$0.00
D1520	Space maintainer-removable-unilateral	$0.00
D1526	Space maintainer - removable, bilateral, maxillary	$0.00
D1527	Space maintainer - removable, bilateral, mandibular	$0.00
BASIC SERVICES (Restorative Codes)		
D2140	Amalgam-one surface, primary or permanent	$21.00
D2150	Amalgam-two surfaces, primary or permanent	$28.00
D2160	Amalgam-three surfaces, primary or permanent	$33.00
D2161	Amalgam-four or more surfaces, primary or permanent	$40.00
D2330	Resin-based composite-one surface, anterior	$24.00
D2331	Resin-based composite-two surfaces, anterior	$32.00
D2332	Resin-based composite-three surfaces, anterior	$38.00
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	$46.00
D2391	Resin-based composite-one surface, posterior	$29.00
D2392	Resin-based composite-two surfaces, posterior	$44.00
D2393	Resin-based composite-three surfaces, posterior	$62.00
D2394	Resin-based composite-four or more surfaces, posterior	$73.00
D2520	Inlay-metallic-two surfaces	$193.00
D2530	Inlay-metallic-three or more surfaces	$223.00
D2543	Onlay-metallic-three surfaces	$233.00
D2544	Onlay-metallic-four or more surfaces	$237.00
D2710	Crown-resin-based composite (indirect)	$161.00
D2740	Crown-porcelain/ceramic substrate	$295.00
D2750	Crown-porcelain fused to high noble metal	$284.00
D2751	Crown-porcelain fused to predominantly base metal	$245.00
D2752	Crown-porcelain fused to noble metal	$275.00

Delta Dental of Colorado
Exclusive Panel Option (EPO)

2020 Schedule EPO 1B
List of Patient Copayments

*See Special Provisions on Last Page

D2780	Crown-3/4 cast high noble metal	$273.00
D2781	Crown-3/4 cast predominantly base metal	$238.00
D2782	Crown-3/4 cast noble metal	$268.00
D2790	Crown-full cast high noble metal	$287.00
D2791	Crown-full cast predominantly base metal	$244.00
D2792	Crown-full cast noble metal	$280.00
D2910	Recement inlay, onlay or partial coverage restoration	$13.00
D2920	Recement crown	$15.00
D2930	Prefabricated stainless steel crown-primary tooth	$45.00
D2931	Prefabricated stainless steel crown-permanent tooth	$49.00
D2932	Prefabricated resin crown	$48.00
D2933	Prefabricated stainless steel crown with resin window	$61.00
D2940	Sedative filling	$16.00
D2950	Core buildup, including any pins	$43.00
D2951	Pin retention-per tooth, in addition to restoration	$10.00
D2952	Cast post and core in addition to crown	$59.00
D2953	Each additional cast post - same tooth	$0.00
D2954	Prefabricated post and core in addition to crown	$51.00
D2957	Each additional prefabricated post - same tooth	$0.00
D2961	Labial veneer (resin laminate)-laboratory	$139.00
D2962	Labial veneer (porcelain laminate)-laboratory	$147.00
BASIC SERVICES (Endodontic Codes)		
D3110	Pulp cap-direct (excluding final restoration)	$10.00
D3220	Therapeutic pulpotomy (excluding final restoration)	$26.00
D3310	Anterior (excluding final restoration)	$110.00
D3320	Bicuspid (excluding final restoration)	$129.00
D3330	Molar (excluding final restoration)	$172.00
D3346	Retreatment of previous root canal therapy-anterior	$191.00
D3347	Retreatment of previous root canal therapy-bicuspid	$225.00
D3348	Retreatment of previous root canal therapy-molar	$297.00
D3410	Apicoectomy/periradicular surgery-anterior	$114.00
D3421	Apicoectomy/periradicular surgery-bicuspid (first root)	$126.00
D3425	Apicoectomy/periradicular surgery-molar (first root)	$150.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$41.00
D3430	Retrograde filling-per root	$34.00
D3450	Root amputation - per root	$80.00
BASIC SERVICES (Periodontic Codes)		
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	$70.00
D4211	Gingivectomy or gingivoplasty-one to three contiguous teeth or bounded teeth spaces per quadrant	$26.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$26.00
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or bounded teeth spaces per quadrant	$112.00
D4241	Gingival flap procedure, including root planing-one to three contiguous teeth or bounded teeth spaces per quadrant	$67.00
D4260	Osseous surgery (including flap entry and closure)-four or more contiguous teeth or bounded teeth spaces per quadrant	$284.00
D4261	Osseous surgery (including flap entry and closure)-one to three contiguous teeth or bounded teeth spaces per quadrant	$170.00
D4263	Bone replacement graft-first site in quadrant	$71.00
D4264	Bone replacement graft-each additional site in quadrant	$47.00
D4277	Free soft tissue graft (including recipient and donor site) first tooth, implant or edentulous tooth positon	$124.00
D4278	Free soft tissue graft (including recipient and donor site) each additional contiguous tooth, implant or edentulous tooth position	$62.00
D4341	Periodontal scaling and root planing-four or more teeth per quadrant	$39.00
D4342	Periodontal scaling and root planing-one to three teeth, per quadrant	$23.00
D4910	Periodontal maintenance	$24.00
MAJOR SERVICES (Prosthodontic Codes - Removable)		
D5110	Complete denture, maxillary	$349.00
D5120	Complete denture, mandibular	$349.00
D5130	Immediate denture, maxillary	$377.00
D5140	Immediate denture, mandibular	$377.00

Delta Dental of Colorado
Exclusive Panel Option (EPO)

2020 Schedule EPO 1B
List of Patient Copayments

*See Special Provisions on Last Page

D5211	Maxillary partial denture-resin base (including retentive/clasping materials, rests and teeth)	$243.00
D5212	Mandibular partial denture-resin base (including retentive/clasping materials, rests and teeth)	$243.00
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$364.00
D5214	Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$364.00
D5221	Immediate maxillary partial denture – resin base	$238.00
D5222	Immediate mandibular partial denture – resin base	$238.00
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases	$331.00
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases	$331.00
D5410	Adjust complete denture, maxillary	$17.00
D5411	Adjust complete denture, mandibular	$17.00
D5421	Adjust partial denture, maxillary	$16.00
D5422	Adjust partial denture, mandibular	$16.00
D5511	Repair broken complete denture base, mandibular	$40.00
D5512	Repair broken complete denutre base, maxillary	$40.00
D5520	Replace missing or broken teeth-complete denture (each tooth)	$34.00
D5611	Repair resin partial denutre base, mandibular	$36.00
D5612	Repair resin partial denutre base, maxillary	$36.00
D5621	Repair cast partial framework, mandibular	$47.00
D5622	Repair cast partial framework, maxillary	$47.00
D5630	Repair or replace broken retentive clasping materials per tooth	$48.00
D5640	Replace broken teeth-per tooth	$33.00
D5650	Add tooth to existing partial denture	$39.00
D5660	Add clasp to existing partial denture	$49.00
D5710	Rebase complete maxillary denture	$141.00
D5711	Rebase complete mandibular denture	$141.00
D5720	Rebase maxillary partial denture	$108.00
D5721	Rebase mandibular partial denture	$108.00
D5730	Reline complete maxillary denture (chairside)	$56.00
D5731	Reline complete mandibular denture (chairside)	$56.00
D5740	Reline maxillary partial denture (chairside)	$51.00
D5741	Reline mandibular partial denture (chairside)	$51.00
D5750	Reline complete maxillary denture (laboratory)	$100.00
D5751	Reline complete mandibular denture (laboratory)	$100.00
D5760	Reline maxillary partial denture (laboratory)	$93.00
D5761	Reline mandibular partial denture (laboratory)	$93.00
D5850	Tissue conditioning, maxillary	$26.00
D5851	Tissue conditioning, mandibular	$26.00
MAJOR SERVICES (Prosthodontic Codes - Fixed)		
D6210	Pontic-cast high noble metal	$274.00
D6211	Pontic-cast predominantly base metal	$250.00
D6212	Pontic-cast noble metal	$255.00
D6240	Pontic-porcelain fused to high noble metal	$276.00
D6241	Pontic-porcelain fused to predominantly base metal	$241.00
D6242	Pontic-porcelain fused to noble metal	$268.00
D6545	Retainer-cast metal for resin bonded fixed prosthesis	$100.00
D6750	Crown-porcelain fused to high noble metal	$280.00
D6751	Crown-porcelain fused to predominantly base metal	$251.00
D6752	Crown-porcelain fused to noble metal	$268.00
D6780	Crown-3/4 cast high noble metal	$272.00
D6790	Crown-full cast high noble metal	$283.00
D6791	Crown-full cast predominantly base metal	$256.00
D6792	Crown-full cast noble metal	$266.00
D6930	Recement fixed partial denture	$33.00
BASIC SURGERY (Oral Surgery Codes)		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$22.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43.00
D7220	Removal of impacted tooth-soft tissue	$48.00

Delta Dental of Colorado
Exclusive Panel Option (EPO)

2020 Schedule EPO 1B
List of Patient Copayments

*See Special Provisions on Last Page

D7230	Removal of impacted tooth-partially bony	$60.00
D7240	Removal of impacted tooth-completely bony	$70.00
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	$100.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$42.00
D7251	Coronectomy - intentional partial tooth removal	$85.00
D7285	Biopsy of oral tissue-hard (bone, tooth)	$58.00
D7286	Biopsy of oral tissue-soft (all others)	$36.00
D7310	Alveoloplasty in conjunction with extractions-per quadrant	$34.00
D7320	Alveoloplasty not in conjunction with extractions-per quadrant	$49.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$68.00
D7472	Removal of torus palatinus	$68.00
D7473	Removal of torus mandibularis	$68.00
D7510	Incision and drainage of abscess-intraoral soft tissue	$25.00
D7960	Frenulectomy (frenectomy or frenotomy)-separate procedure	$51.00
ORTHODONTIC CODES		
D8010	Limited orthodontic treatment of the primary dentition	$600.00
D8020	Limited orthodontic treatment of the transitional dentition	$750.00
D8030	Limited orthodontic treatment of the adolescent dentition	$840.00
D8040	Limited orthodontic treatment of the adult dentition	$935.00
D8050	Interceptive orthodontic treatment of the primary dentition	$730.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$825.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,685.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,780.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,980.00
D8210	Removable appliance therapy	$180.00
D8220	Fixed appliance therapy	$238.00
D8660	Pre-orthodontic treatment visit	$35.00
D8670	Periodic orthodontic treatment visit	$9,999.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$213.00
MISCELLANEOUS CODES		
D9110	Palliative (emergency) treatment of dental pain-minor procedures	$18.00
D9120	Fixed partial denture sectioning	$9.00
D9222	Deep sedation/general anesthesia - first 15 minutes	$27.00
D9223	Deep Sedation/general anesthesia - each subsequent 15 minute increment	$27.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$8.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$30.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minutes	$30.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$14.00

* SPECIAL PROVISIONS:

Services MUST be performed by a Delta Dental PPO™ dentist in order to be payable under this program.

Services are subject to the limitations, exclusions, and governing policies of the program.

The submitted fee for any procedure NOT LISTED is the responsibility of the patient.

General or orthodontic plan maximums may apply. Refer to the member's benefit information.

Delta Dental of Colorado
Group Dental Plan

CONTACT US

Visit Delta Dental's Website:
www.deltadentalco.com

You can search for a Provider, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

TABLE OF CONTENTS

ELIGIBILITY

All eligible Subscribers and their dependents that enroll will be covered on the effective date. All Subscribers will become eligible as determined by the employer group.

This policy is effective at 12:00 a.m. on the date of enrollment and will terminate at 11:59 p.m. on the date of termination.

DEPENDENTS: For your dependents to be insured, you will have to pay the required premium for the cost of having dependents on your insurance. Your dependents will be insured only if you are insured.

No one may be covered as a Dependent and as a Subscriber under this plan. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Benefits for a Dependent Child will continue until the last day of the calendar month in which the limiting age is reached.

Persons in active military service are not eligible Dependents.

Dependents of an eligible Subscriber may enroll within 31 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the subscriber.
- New Dependents must be enrolled within 31 days and will be covered the effective date of the event. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Plan is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.
- The date upon which they lose coverage through another source, if they show proof of loss. (Loss of coverage is any loss due to death, divorce, loss of job, or termination of benefits by the subscriber). The effective date will be the date immediately following the loss of coverage date.

If not added within the 31 day timeframe, the Dependent can be added during the Open Enrollment period, if applicable.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS (Applicable to Managed Care Plans)

How to Find a Provider

There are two easy ways to find out if your Provider is a Delta Dental PPO Network Provider.

1. **Visit our website at www.deltadentalco.com** or
2. **Phone our automated call center** at 1-800-610-0201.

The network is subject to change. Please check on the status of your Provider before your next treatment.

You need not obtain approval before being treated. Before starting treatment that may cost $400 or more, you may request an estimate from Delta Dental. Pre-treatment estimates are not required.

BENEFITS/COVERAGE (What is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

Adjunctive: Certain additional Services, including emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Two exams in any 12 month period are covered. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider.
Dental Cleaning	Two cleanings in any 12 month period are covered. An adult cleaning is not covered for persons under age 14. For those with any condition(s) listed below, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a 12 month period. • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis, and • Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.
Bitewing X-rays	Covered one time in a 12 month period.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 60 month period.
Individual Periapical X-rays **Intraoral Occlusal X-rays** **Extraoral X-rays**	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children through age 14. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered once in a 12 month period for children through age 15.
Space Maintainer	Covered for children through age 13 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 12 months have passed since the filling was placed
Stainless Steel Crowns Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a 12 month period.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - Coronal Remnants Deciduous Tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - Erupted Tooth or Exposed Root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if the first root canal procedure on the same tooth was performed at least 24 months earlier.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings), are limited to 4 per any 12 month period.

Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.
Crown Lengthening - Hard Tissue, by Report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Surgical Extractions of Teeth or Tooth Roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.

MAJOR SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns, Inlays and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.
Denture Adjustments	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning per Denture Unit	Covered two times in a 36 month period.
Relining Dentures **Rebasing Dentures**	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.
Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 60 months have passed since the last placement. Not covered for children under age 12.
Crowns and Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 60 months since the last placement. Not covered for children under age 12**.**

Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Fixed Bridges	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 60 months old, is not serviceable, and cannot be repaired, and there is no prior payment of covered Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Full Dentures	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.
Temporary Removable Partial Dentures	Initial temporary removable partial dentures are covered to replace missing permanent front teeth. Replacement is covered only after 60 months have elapsed since the last placement.

ORTHODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Provider involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility. c) The initial orthodontic benefit payment for a comprehensive treatment plan of 13 months or more will be made in two (2) payments. The 1st payment will be issued at banding date or insertion. The 2nd payment will be issued 12 months later. The final payment will be reduced by any other orthodontic benefits issued that applied to the orthodontic plan maximum. Only members eligible in the Plan 12 months after initial banding or insertion will receive the final payment. d) The orthodontic payment benefit for treatment plans 12 months or less will be made in 1 payment at time of banding or insertion. This payment will be reduced by any other orthodontic benefits issued that applied to the plan's orthodontic maximum. e) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, Delta Dental will reduce periodic payments using its applicable processing polices.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a) Alternate Benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive alternate benefits.**

b) Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service.

c) Plan will pay Procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.

d) Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.

e) Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

f) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

g) The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

h) Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.

i) Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.

b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.

c) Services for treatment of birth or developmental defects, ***except*** Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate

d) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.

e) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.

f) Services resulting from improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth (splinting).

h) Habit appliances, night guards, occlusal guards, athletic mouth guards and jaw function services, bite registration or analysis, or any related services.

i) Patient management services (***except*** covered anesthetic services).

j) Charges for prescribed drugs.

k) Any Experimental or Investigational treatment.

l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.

m) Any treatment done in anticipation of future need (***except*** covered preventive services).

n) Hospital costs or any charges for use of any facility.

o) Any anesthesia service not included in Covered Services.

p) Grafts done in the mouth where teeth are not present.

q) Grafts of tissues from outside the mouth into the mouth.

r) Therapy for speech or the function of the tongue or face.

s) Orthodontic Services unless shown as covered on the Schedule of Benefits.

t) Implant Services unless shown as covered on the Schedule of Benefits.

u) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.

v) Services not performed in accordance with Colorado state law. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.

w) Teaching services.

x) Completion of forms. Providing diagnostic information. Copying of other records.

y) Replacement of lost, stolen or damaged items.

z) Repair of items altered by someone other than a Provider.

aa) Any Services not included in Covered Services.

bb) Services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid.
cc) Missed appointment charges.
dd) Preventive control programs, including home care items.
ee) Plaque control programs.
ff) Self-injury.
gg) Provisional splinting.
hh) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
ii) Services provided for treatment of teeth retained in relation to an Overdenture.
jj) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
kk) Any Special Restorative service provided within 60 months of fixed Prosthodontic services involving the same teeth.
ll) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.

MEMBER PAYMENTS RESPONSIBILITY

You must pay deductibles, amounts above the annual maximum, amounts up to the out-of-pocket maximum, and your coinsurance. You must pay charges for Services not covered under this plan. You may be responsible for some part of the premium.

CLAIM PROCEDURES (How to File a Claim)

If you are covered by more than one dental plan, you should file all of your claims with each plan.

Delta Dental will not pay claims submitted more than 12 months after the date of service.

PRE-TREATMENT ESTIMATE

Before starting treatment that may cost $400 or more, you may request an estimate of what is covered. Pre-treatment estimates are not required.

RIGHT TO EXAMINATION

Delta Dental shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy.

GENERAL POLICY PROVISIONS

AGREEMENT WITH STATE LAW

Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Covered Person lives is hereby changed to the minimum requirement of such laws.

ASSIGNMENT OF BENEFITS

You may assign any benefits of this policy to your dental provider. You may revoke this assignment at any time by sending a written revocation to Delta Dental.

NON-DISCRIMINATION

With regard to participation in its networks, Delta Dental does not discriminate against any provider acting in the scope of his or her license.

COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits. For the complete listing of your policy's coordination of benefits provisions, please contact your group plan administrator or the state Division of Insurance.

Double Coverage

Family members may be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your group plan administrator or your state insurance department for a full review of coordination of benefits requirements.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary.

When This Plan is Primary
If you or a family member are covered under another plan in addition to this one, Delta Dental will be primary when:

Your Own Expenses
▪The claim is for your own health care expenses, unless you are covered by Medicare Advantage and both you and your spouse are retired.

Your Child's Expenses
▪The claim is for the health care expenses of your child who is covered by this plan and

▪you are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";
or
▪you are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;
or
▪there is no court decree, but you have primary custody of the child.

Other Situations
We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary
When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary
We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

▪If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the contract calls for Health maintenance organizations (HMO) and preferred Provider organizations (PPO) usually have contracts with their Providers.

▪We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

▪If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we may pay for those expenses. We will not pay an amount the primary plan did not cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions about Coordination of Benefits?

Colorado Division of Insurance
1560 Broadway, Ste 850
Denver, CO 80202
Phone Number: 303-894-7490 or 1-800-930-3745

SUBROGATION

Delta Dental has the right to enforce on its own, or with a covered person, a claim against a third party up to the amount paid by Delta Dental. If Delta Dental pays a claim for injuries to a covered person and the covered person settles with a third party for an amount that includes such costs, the covered person must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the covered person.

HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, your employer has agreed to:

a) Not use or disclose health information other than as permitted or as required by law.
b) Ensure that any agents who receive protected health information (PHI) agree to the same restrictions that apply to your employer.
c) Not use or disclose PHI for employment actions and decisions.
d) Report to the Plan any improper use or disclosure of PHI that they are aware of.
e) Make PHI available for your own use and provide you with the right to amend or correct your own PHI upon request.

f) Provide an accounting of its disclosures to individuals and make its practices relating to the use or disclosure of PHI available to the Secretary of HHS.
g) Ensure that there is separation between the Plan and the Plan Sponsor as required by HIPAA. Ensure that there are reasonable security controls.
h) If possible, return or destroy all PHI received from the Plan when no longer needed.
i) Implement safeguards that protect electronic PHI that is managed on behalf of the group health plan.
j) Ensure that any agent to whom it provides electronic PHI agrees to implement security measures to protect the information.
k) Report to the group health plan any security incident of which it becomes aware.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access this information.

Delta Dental is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information. This notice is effective on the date your group coverage went into effect.

How We May Use and Disclose Health Information About You
In almost all cases, we may use and disclose protected health information for treatment, payment, and health care operations. For example, we may use and disclose protected health information:

1. To communicate with the provider who provides, coordinates, or manages your care,
2. To determine how much or whom we should pay for covered services,
3. To assess the quality of care that our participating providers provide.

Other categories describing how we may use and disclose your health information are listed below, along with some examples of these uses and disclosures.

To You and With Your Written Authorization: We may disclose your health information to you in the manner and for the purposes described in the "Your Rights" section of this Notice. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your prior authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information to any person or for any reason not permitted by law.
An authorization is required for uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information. Any other uses and disclosures not specifically described in this notice will be made only with the individual's authorization.
To Your Family and Friends: We may disclose your health information to a family member, friend or other person if you provide us written authorization to do so.
Disclosure to Plan Sponsors: For example, to help the sponsor of your group health plan administer your benefits.
Health Related Benefits and Services: We may use or disclose health information about you to communicate to you about health-related benefits and services.
Research: We may use or disclose health information about you for research purposes. If we do, Delta Dental may be required to obtain an authorization from you for such use or disclosure.
Public Health and Safety: For example, to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.
Required by Law: For example, as required by federal or state statute or regulation, worker's compensation or similar laws and state insurance and health regulatory authorities.
Lawsuits and Disputes: For example, in the course of any administrative or judicial proceeding.
Law Enforcement: For example, to identify or locate a suspect or to comply with a court order, a court ordered warrant, or a subpoena or summons issued by an officer of the court.
Military and National Security: For example, military, lawful intelligence, counter-intelligence, and other national security activities.

Your Rights Regarding Health Information About You
You have the following rights regarding health information we maintain about you:

- **Your Right to Inspect and Copy Your Health Information:** To inspect and copy such information, you must submit your request in writing. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.
- **Your Right to Amend Protected Health Information:** You may request that Delta Dental change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

- **Your Right to an Accounting of Disclosures Made by Delta Dental:** You may request an accounting of disclosures made for purposes other than treatment, payment, health

care operations or made to you. You must submit your request in writing. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Delta Dental will provide the first accounting per 12-month period free of charge; we may charge you for additional reports.

- **Your Right to Request Restrictions on Uses and Disclosures:** Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.
- **Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location:** To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.
- **Your Right to a Paper Copy of this Notice:** You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.
- **Your Right to Opt Out of Fundraising Communications:** Delta Dental does not intend to contact you to raise funds, but if it does engage in fundraising, you have the right to opt-out of receiving any fund raising communications.
- **Your Right to Breach Notification:** You have the right to be notified of a breach of unsecured protected health information. Delta Dental will provide you the date and description of the information disclosed. You will be notified who the information was disclosed to if we are able. You will be notified by mail within 60 days from the date that we discover the breach.
- **Your Right to Obtain Additional Information or File a Complaint:** Send us a written request if you would like to have a more detailed explanation of these rights. Complaints about how we handle your health information should be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. Delta Dental will not retaliate against you in any way if you choose to file a complaint with us or with the department.

Genetic Information Nondiscrimination Act: Delta Dental is prohibited from using or disclosing genetic information for underwriting purposes.

Changes to this Notice

Delta Dental can amend this Notice at any time in the future and make the new Notice provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to you whenever we make significant changes. Delta Dental is required by law to comply with the current version of this Notice.

Send Written Requests Regarding this Privacy Notice to:

Privacy Officer
PO Box 5468
Denver CO 80217-5468
Or You May Call: 1-800-233-0860

TIME LIMIT ON CERTAIN DEFENSES

(a) After two years from the date of issue of this policy, the validity of this policy shall not be contested, except for non-payment of premiums, and no misstatements made by the applicant in order to acquire such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such two-year period. However, if such statement was made in writing signed by the person making the statement and a copy of that writing is presented to the maker of the statement, such statement may be used by Delta Dental to avoid the policy or reduce benefits.

(b) No claim for loss incurred after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) If this is an individual disability income insurance policy then no claim for loss incurred after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

TERMINATION/NONRENEWAL/ CONTINUATION

A Subscriber's plan will terminate at the earliest of:

- The date Delta Dental of Colorado receives a written request to cancel. Coverage will end at the end of the month following notification, or at the end of the month of the life changing event. We reserve the right to recover

any benefit payment made for dates of service after the terminate date.

- The date the Subscriber is not eligible for coverage under the terms of this policy.
- The date the benefits described in the Policy are terminated.
- When the required premium has not been paid (Subject to the applicable grace period).
- When you commit fraud or intentional misrepresentation of material facts.
- For the Subscriber, 12 months from the date the member enters active military service.
- For Dependents, the end of the month following active military service.
- Upon the Subscriber's death.

To remove a Dependent from the plan, the Subscriber must notify us of the termination within 31 days. The Effective Date of the change will be the end of the month in which the change was effective. We reserve the right to recover any benefits payments made for dates of service after the termination date.

Benefits for a Dependent ends on the last day of the month for the following life changing events:

- The date the benefits described in the policy are terminated.
- The date the Dependent is not eligible for coverage under the terms of this policy.
- When the Dependent child no longer qualifies as a Dependent by definition.
- When legal custody of a child placed for adoption is terminated.
- When the required premium has not been paid.
- Upon the Dependent's death.

EXTENDED COVERAGE
(Paying for Benefits after Termination)

Delta Dental benefits will end if this Policy is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service started before coverage ends, but the Covered Service is completed after coverage ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is started after coverage ends.

NONRENEWAL

This policy will automatically renew. If you don't want to renew this policy, contact Delta Dental of Colorado before the policy's renewal date. If you do not renew this policy, the policy will end on the last day before the renewal date. Delta Dental can nonrenew this policy by sending you written notice (either electronically or through the mail) at least 60 days before the renewal dates. If we do, this policy will end on the last day before the renewal date.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Covered persons may be able to continue coverage through COBRA. The benefits will be the same as the benefits active Subscribers receive. The Covered person must pay the entire Premium, which cannot exceed 102% of the cost for an active Subscriber with the same Plan. You should contact your employer to determine if you are able to continue coverage through COBRA.

Continued Health Coverage required by the State of Colorado

If you are not eligible for COBRA you may be eligible to continue coverage for up to 18 months under State Continuation. Contact your employer to learn if you are eligible to continue coverage through state continuation.

APPEALS AND COMPLAINTS

Internal Appeal Process - First Level Appeals:
A Subscriber may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A Subscriber may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Subscriber with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

Internal Appeal Process - Expedited Appeals:

Subscribers may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Subscriber, would jeopardize the Subscriber's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

Independent External Review:
Where Delta Dental makes an Adverse Determination and the Subscriber exhausts the internal appeals process, the Subscriber has the right to request an external review. Delta Dental will notify the Subscriber of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Subscriber must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Subscriber's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Subscriber may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Subscriber, Delta Dental, the provider, and the Commissioner.

INFORMATION ON POLICY AND RATE CHANGES

No change in your policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed on the policy. No agent has authority to change this policy or to waive any of its provisions except where approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer. Any such amendment that reduces or eliminates coverage shall have been either requested in writing or signed by your Employer.

If there are changes to the information provided in this document, we will issue revised materials to you.

DEFINITIONS

ALTERNATE BENEFIT means the benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the covered person selects.

BENEFITS means those Services and supplies covered pursuant to the terms of this plan. Benefits for all Covered Services are subject to the limitations and exclusions noted in this Benefit Booklet.

COINSURANCE means the percentage of a Covered Amount which is payable by Delta Dental. The Coinsurance for each type of Covered Service is shown on the Schedule of Benefits. The Coinsurance applicable will vary depending upon the type of dental Service.

COMPLETED means:

- For Root Canal Therapy: The date the canals are permanently filled.
- For Fixed bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place, regardless of the type of cement used.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

For claim payment purposes, the date Completed will be the date when a claim is incurred.

DEDUCTIBLE means the amount that must be paid by the covered person before Delta Dental will make payment. The amount of the Deductible is shown on the Schedule of Benefits. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DENTAL INJURY is an injury to a Sound Natural Tooth (other than a chewing injury) of a Covered person which results solely from a sudden, unexpected violent act or accident. A chewing injury is any injury that occurs from biting or chewing food or a foreign object.

DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner, or domestic partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- Domestic partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old and view themselves as a family.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be married and may not have another partner.
  - ❖ They must have lived together for at least 6 consecutive months.
  - ❖ They must not be related.
  - ❖ They must be financially interdependent.
- A child under the Dependent Age Limit shown on the Schedule of Benefits.
- A child who reaches the Dependent Age Limit stated on the Schedule of Benefits and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children include natural children, stepchildren, children under court-ordered guardianship, adopted children, and children of a civil union or domestic partner.

No one may be covered as a Dependent and also as a Subscriber under this Plan. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

EFFECTIVE DATE is the date coverage begins

EMERGENCY TREATMENT or EMERGENCY SERVICE means any required Service that is provided as the direct result of an unforeseen occurrence that requires immediate, urgent action.

EMPLOYEE means someone who works the minimum number of hours as defined by the employer.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those services or supplies that are not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount for a procedure as determined by Delta Dental.

NECESSARY means a Service that is required by, and appropriate for treatment of, the Covered person's dental condition according to generally accepted standards of dental care as determined by Delta Dental.

OUT-OF-POCKET MAXIMUM means the maximum amount you will have to pay for allowable covered expenses under this plan.

POLICY means the agreement between Delta Dental and the applicant. This Policy is the whole agreement between the parties and no change is allowed unless approved by the insurer.

POLICY TERM means the time from the Effective Date of the Policy until it is terminated.

POLICY YEAR is the 365 days beginning on the Effective Date of this Policy, and each year after unless the Policy is terminated. The Policy Year is 366 days in a leap year.

PROVIDER means a person licensed to practice dentistry.

STARTED means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is actually performed.
- For All Other Services: The date the Service is performed.

SUBSCRIBER means the person in whose name the membership under the policy is established. A person who elects continued coverage and for whom the monthly Premium is paid.

Visit Delta Dental's Website at:
www.deltadentalco.com

You can search for a Provider, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

Delta Dental PPO Plan

Adams County Colorado
Retiree Plan
Group #7738
Revised: January 1, 2020

Delta Dental PPO
Schedule of Benefits
For Group #7738
ADAMS COUNTY COLORADO – RETIREE PLAN

This Schedule of Benefits should be read in conjunction with your Subscriber Benefit Booklet. Your Subscriber Benefit Booklet will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **In the event that you seek treatment from a non-participating provider, you may have more out-of-pocket costs.**

Control Plan - Delta Dental of Colorado
Benefit Year - January 1st to December 31st

	PPO Provider	Delta Dental Premier Provider	*Non-Participating Provider
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Oral Exams and Cleanings	100%	100%	100%
Sealants	100%	100%	100%
Fluoride Treatment	100%	100%	100%
All X-Rays	80%	80%	80%
Basic Services			
Basic Restorative (Fillings)	80%	80%	80%
Simple Extractions	80%	80%	80%
Major Services			
Complex Oral Surgery	50%	50%	50%
Denture Repair/Relines/Rebases	50%	50%	50%
Endodontics (Root Canal Therapy)	50%	50%	50%
Periodontics (Gum Disease Treatment)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%

Orthodontia is not a covered benefit.

***Important: Non-Participating Providers are allowed to balance bill. Subscribers and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month

Deductible (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes	Individual coverage amount	PPO and Non-PPO	$75

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P	Individual coverage amount	PPO and Non-PPO	$2000

Enrollment Type

The enrollment type is Late Enrollment (A Late Enrollee must be enrolled for 12 consecutive months before Type II or Type IIIA Services will be covered, and 24 consecutive months before Type IIIB Services will be covered. LATE ENROLLMENT means enrollment occurring after the period of initial eligibility. The exception to this rule is a Dependent who involuntarily loses coverage through another group insurance plan. (Involuntary loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the Employer. Such Dependent will be allowed to enroll within 31 days of the loss of coverage with satisfactory proof of coverage loss and will not be considered a Late Enrollee upon enrollment.

Where two Employees who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent.

Eligible Participants – All county retirees are eligible within 60 days of retirement. Also eligible at your option are your spouse and dependent children to the end of the month in which they attain age 26.

Under the Delta Dental PPO plan, you may visit any Provider of your choice. There are three levels of Providers to choose from who are located nationwide:

PPO Participating Provider

Advantages of seeing a PPO Provider include:

- Payment is based upon the PPO Provider's Allowable fee, or the fee actually charged, whichever is less.
- You are responsible for any applicable deductible and coinsurance for covered procedures.

You will receive the best benefits available on this plan by choosing a PPO Provider.

Premier Participating Provider (Non-PPO)

You have the option of seeing a Premier Provider, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

Non-Participating Provider (Non-PPO)
You have the option of seeing a non-participating Provider, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Provider and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.

COVERED AMOUNT means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Colorado counties without PPO or Premier Providers are Bent, Conejos, Costilla, Crowley, Dolores, Gilpin, Hinsdale, Jackson, Kiowa, Mineral, Rio Blanco, Saguache, San Juan, and Sedgwick.

Delta Dental of Colorado
Group Dental Plan

CONTACT US

Visit Delta Dental's Website:
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Denver, CO 80237

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ELIGIBILITY

All eligible Retirees and their dependents who enroll will be covered on the effective date. All Retirees will become eligible as determined by the employer group.

This policy is effective at 12:00 a.m. on the date of enrollment and will terminate at 11:59 p.m. on the date of termination.

DEPENDENTS: For your dependents to be insured, you will have to pay the required premium for the cost of having dependents on your insurance. Your dependents will be insured only if you are insured.

A Retiree's Dependents may include the following:

- The Retiree's lawful spouse.
- Newborn Child.
- Adopted Child. An unmarried child under the age of 26 years.
- A **Dependent child** under the Dependent Age Limit of 26 years of age. Eligible children are natural children, stepchildren, those under court-ordered guardianship, and adopted children.
- **Disabled Dependent Child**. A Dependent child who reaches the Dependent Age Limit of 26 and who is not capable of self-support because of physical or mental disabilities. The disabilities must have been present when the child reached the Dependent Age Limit. The child must be dependent on the Retiree. Delta Dental may request proof of disability and dependency each year. Failure to submit such proof will terminate coverage.

No one may be covered as a Dependent and as a Retiree under this plan. If both parents are covered as Retirees, children may be covered as Dependents of one parent only.

Benefits for a Dependent Child will continue until the last day of the calendar month in which the limiting age is reached.

Persons in active military service are not eligible Dependents.

Dependents of an eligible Retiree may enroll within 31 days of the following:

- The date the Retiree becomes eligible to enroll. The effective date is that of the retiree.
- New Dependents must be enrolled within 31 days and will be covered effective date of the event. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Plan is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.
- The date upon which they lose coverage through another source, if they show proof of loss. (Loss of coverage is any loss due to death, divorce, loss of job, or termination of benefits by the retiree). The effective date will be the date immediately following the loss of coverage date.

If not added within the 31 day timeframe, the Dependent can be added during the Open Enrollment period, if applicable.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS (Applicable to Managed Care Plans)

How to Find a Provider

There are two easy ways to find out if your Provider is a Delta Dental PPO Network Provider.

1. **Visit our website at www.deltadentalco.com** or
2. **Phone our automated call center** at 1-800-610-0201.

The network is subject to change. Please check on the status of your Provider before your next treatment.

You need not obtain approval before being treated. Before starting treatment that may cost $400 or more, you may request an estimate from Delta Dental. Pre-treatment estimates are not required.

BENEFITS/COVERAGE (What is Covered)

COVERED DENTAL SERVICES

TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	One exam in any 12 month period is covered. One comprehensive or detailed and extensive oral exam is covered per covered person per dental office. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider.
Dental Cleaning	One cleaning in any 6 month period is covered. Not covered within 6 months of a periodontal maintenance procedure. An adult cleaning is not covered for persons under the age of 14.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children under age 15. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered one time in a 12 month period for children under the age of 16.
Space Maintainer	Covered for children under the age of 14 to maintain space left by prematurely lost baby back teeth.
Bitewing X-rays	Covered one time in a 12 month period.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 60 month period.
Individual Periapical Xrays Intraoral Occlusal X-rays Extraoral X-rays	A maximum of 4 periapical x-rays are covered in a 12-month period when submitted separately. Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee for any combination of individually submitted x-rays meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 24 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 24 months have passed since the filling was placed. Composite resin fillings on back teeth will be covered up to the cost of an amalgam filling.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - coronal remnants deciduous tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - erupted tooth or exposed root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit if no other service is performed during the visit except an exam and/or x-rays.

MAJOR – ENDODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal Therapy	Covered if the first root canal procedure on the same tooth was performed at least 36 months earlier.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 36 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 36 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.

MAJOR – PERIODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Covered if 3 months have passed since the completion of active periodontal therapy (gum surgery or scaling and root planing). Then one time in any 6 month period. Not covered if performed within 6 months of a routine cleaning.
Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.
Crown lengthening-hard tissue, by report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.

MAJOR – COMPLEX ORAL SURGERY SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Surgical Extractions of teeth, or tooth roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately covered.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.

MAJOR – PAIN MANAGEMENT SERVICES

PROCEDURE	BENEFIT DESCRIPTION
General Anesthesia Analgesia (Nitrous Oxide) I.V. Sedation	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.

MAJOR – ADJUSTMENT AND REPAIR SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns, Inlays and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.

MAJOR – DENTURE ADJUSTMENT, REPAIR, RELINE AND REBASE SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Denture Adjustments*	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures*	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning per Denture Unit*	Covered two times in a 36 month period.
Relining Dentures or Rebasing Dentures	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.

***Adjustments associated with initial placement of a new completed partial denture are included in the cost of the appliance.**

MAJOR – INLAY, ONLAY AND CROWN SERVICES

(Temporary restorations and appliances are not covered separately.)

PROCEDURE	BENEFIT DESCRIPTION
Metallic Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 84 months have passed since the last placement. Not covered for children under age 16.
Crowns and Metallic Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 84 months since the last placement. Not covered for children under age 16.
Stainless Steel Crowns, Resin Crowns	Covered once in 36 months when the tooth cannot be restored by a filling. Covered only for children to age 16. Prefabricated resin crowns are a benefit only on front teeth. Replacement of a prefabricated crown is not covered within 36 months of placement of an existing prefabricated crown.
Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 84 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 84 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.

MAJOR – FIXED BRIDGEWORK SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Fixed Bridges (Only a benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under the Contract or another Delta Dental Plan sponsored by Adams County Government.	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 84 months old, is not serviceable, and cannot be repaired, and there is no prior payment of covered special restorative or prosthodontic benefit for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 84 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Post and Core (in conjunction with a fixed bridge	Benefit on endodontically treated teeth, when required for retention of a fixed bridge and only necessary due to extensive loss of tooth structure caused by decay or fracture.

MAJOR – DENTURES AND PARTIAL DENTURES

PROCEDURE	BENEFIT DESCRIPTION
Full Dentures (Only a benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under the Contract or another Delta Dental Plan sponsored by Adams County Government.	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures (Only a benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under the Contract or another Delta Dental Plan sponsored by Adams County Government.	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a) Alternate Benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive alternate benefits.**

b) Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service.

c) Plan will pay Procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.

d) Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.

e) Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

f) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

g) The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

h) Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.

i) Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.

b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.

c) Services for treatment of birth or developmental defects, ***except*** **Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate.**

d) Any treatment provided primarily for cosmetic purposes. Veneers on molar teeth and facings or veneers placed on crowns or bridge units for molar teeth will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.

e) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.

f) Services resulting from improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth (splinting).

h) Habit appliances, night guards, occlusal guards, athletic mouth guards and jaw function services, bite registration or analysis, or any related services.

i) Patient management services (***except*** covered anesthetic services).

j) Charges for prescribed drugs.

k) Any Experimental or Investigational treatment.

l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.

m) Any treatment done in anticipation of future need (***except*** covered preventive services).

n) Hospital costs or any charges for use of any facility.

o) Any anesthesia service not included in Covered Services.

p) Grafts done in the mouth where teeth are not present.

q) Grafts of tissues from outside the mouth into the mouth.

r) Orthodontic Services unless shown as covered on the Schedule of Benefits.

s) Implant Services unless shown as covered on the Schedule of Benefits.

t) Therapy for speech or the function of the tongue or face.

u) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.

v) Services not performed in accordance with Colorado state law. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.

w) Teaching services.

x) Completion of forms. Providing diagnostic information. Copying of other records.

y) Replacement of lost, stolen or damaged items.

z) Repair of items altered by someone other than a Provider.

aa) Any Services not included in Covered Services.
bb) Services for which charges would not have been made but for this coverage, except for Services provided under Medicaid.
cc) Missed appointment charges.
dd) Preventive control programs, including home care items.
ee) Plaque control programs.
ff) Self-injury.
gg) Initial placement of a denture unless needed to replace at least one Functioning Natural Tooth pulled while the Person was covered under this Plan. One full or partial denture is covered per arch in any 60-month period.
hh) The first fixed bridge unless it is needed to replace a Functioning Natural Tooth pulled while the Person was insured under this Plan, and if that tooth was not an abutment to an existing fixed bridge which is less than 84-months old. If a bridge replaces more than one pulled permanent Natural Tooth, benefit will be limited to the replacement of those teeth which were pulled while the Person was covered under the Plan.
ii) Replacement of a complete denture, partial denture, or fixed bridge is not a Covered Service unless:
    1. replacement of the current denture occurs at least 60 months after the date of insertion, even if the existing appliance was not provided under this Plan; or
    2. replacement of an existing fixed bridge occurs at least 84 months after the date of insertion, even if the existing appliance was not provided under this Plan; or
    3. the replacement appliance is required by the Necessary extraction of a Functioning Natural Tooth while the Person is covered; or
    4. the replacement is made Necessary by a covered Dental Injury to Sound Natural Teeth provided the treatment is Started within 60 days of the injury. (Chewing injuries are not considered covered Dental Injuries).
jj) The replacement of a fixed bridge unless the existing fixed bridge is at least 84 months old, cannot be serviced, and cannot be repaired. This requirement applies even if the existing fixed bridge was not provided under this Plan.
kk) The replacement of an existing crown, inlay, onlay or other cast restoration, unless the existing cast restoration is at least 84 months old, is not serviceable and cannot be repaired. The time requirement applies even if the existing cast restoration was not provided under this Plan.
ll) Prefabricated stainless steel and resin crowns are a benefit for covered children to age 16, subject to any Waiting Period or reduced Coinsurance which might apply. Prefabricated resin crowns are a benefit on front teeth. Replacement of a prefabricated crown is not covered within 36 months of the placement of an existing prefabricated crown.
mm) No benefit will be provided for temporary partial dentures. Charges for temporary partial dentures are not covered.
nn) Provisional splinting.
oo) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
pp) Services provided for treatment of teeth retained in relation to an Overdenture.

MEMBER PAYMENTS RESPONSIBILITY

You must pay deductibles, amounts above the annual maximum, amounts up to the out-of-pocket maximum, and your coinsurance. You must pay charges for Services not covered under this plan. You may be responsible for some part of the premium.

CLAIM PROCEDURES (How to File a Claim)

If you are covered by more than one dental plan, you should file all of your claims with each plan.

Delta Dental will not pay claims submitted more than 12 months after the date of service.

PRE-TREATMENT ESTIMATE

Before starting treatment that may cost $400 or more, you may request an estimate of what is covered. Pre-treatment estimates are not required.

RIGHT TO EXAMINATION

Delta Dental shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy.

GENERAL POLICY PROVISIONS

AGREEMENT WITH STATE LAW

Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Covered Person lives is hereby changed to the minimum requirement of such laws.

ASSIGNMENT OF BENEFITS

You may assign any benefits of this policy to your dental provider. You may revoke this assignment at any time by sending a written revocation to Delta Dental.

NON-DISCRIMINATION

With regard to participation in its networks, Delta Dental does not discriminate against any provider acting in the scope of his or her license.

COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits. For the complete listing of your policy's coordination of benefits provisions, please contact your group plan administrator or the state Division of Insurance.

Double Coverage

Family members may be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your group plan administrator or your state insurance department for a full review of coordination of benefits requirements.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, Delta Dental will be primary when:

Your Own Expenses

▪The claim is for your own health care expenses, unless you are covered by Medicare Advantage and both you and your spouse are retired.

Your Child's Expenses

▪The claim is for the health care expenses of your child who is covered by this plan and

- ▪you are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";

or

- ▪you are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;

or

- ▪there is no court decree, but you have primary custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

▪If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the contract calls for Health maintenance organizations (HMO) and preferred Provider organizations (PPO) usually have contracts with their Providers.

▪We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

▪If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we may pay for those expenses. We will not pay an amount the primary plan did not cover because you didn't follow its rules and procedures.

For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?
Colorado Division of Insurance
1560 Broadway, Ste 850
Denver, CO 80202
Phone Number: 303-894-7490 or 1-800-930-3745

SUBROGATION

Delta Dental has the right to enforce on its own, or with a covered person, a claim against a third party up to the amount paid by Delta Dental. If Delta Dental pays a claim for injuries to a covered person and the covered person settles with a third party for an amount that includes such costs, the covered person must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the covered person.

HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, your employer has agreed to:

a) Not use or disclose health information other than as permitted or as required by law.
b) Ensure that any agents who receive protected health information (PHI) agree to the same restrictions that apply to your employer.
c) Not use or disclose PHI for employment actions and decisions.
d) Report to the Plan any improper use or disclosure of PHI that they are aware of.
e) Make PHI available for your own use and provide you with the right to amend or correct your own PHI upon request.
f) Provide an accounting of its disclosures to individuals and make its practices relating to the use or disclosure of PHI available to the Secretary of HHS.
g) Ensure that there is separation between the Plan and the Plan Sponsor as required by HIPAA. Ensure that there are reasonable security controls.
h) If possible, return or destroy all PHI received from the Plan when no longer needed.
i) Implement safeguards that protect electronic PHI that is managed on behalf of the group health plan.
j) Ensure that any agent to whom it provides electronic PHI agrees to implement security measures to protect the information.
k) Report to the group health plan any security incident of which it becomes aware.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access this information.

Delta Dental is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information. This notice is effective on the date your group coverage went into effect.

How We May Use and Disclose Health Information About You
In almost all cases, we may use and disclose protected health information for treatment, payment, and health care operations. For example, we may use and disclose protected health information:

1. To communicate with the provider who provides, coordinates, or manages your care,
2. To determine how much or whom we should pay for covered services,
3. To assess the quality of care that our participating providers provide.

Other categories describing how we may use and disclose your health information are listed below, along with some examples of these uses and disclosures.

To You and With Your Written Authorization: We may disclose your health information to you in the manner and for the purposes described in the "Your Rights" section of this Notice. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your prior authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information to any person or for any reason not permitted by law.
An authorization is required for uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information. Any other uses and disclosures not specifically described in this notice will be made only with the individual's authorization.
To Your Family and Friends: We may disclose your health information to a family member, friend or other person if you provide us written authorization to do so.
Disclosure to Plan Sponsors: For example, to help the sponsor of your group health plan administer your benefits.
Health Related Benefits and Services: We may use or disclose health information about you to communicate to you about health-related benefits and services.
Research: We may use or disclose health information about you for research purposes. If we do, Delta Dental may be required to obtain an authorization from you for such use or disclosure.
Public Health and Safety: For example, to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Required by Law: For example, as required by federal or state statute or regulation, worker's compensation or similar laws and state insurance and health regulatory authorities.
Lawsuits and Disputes: For example, in the course of any administrative or judicial proceeding.
Law Enforcement: For example, to identify or locate a suspect or to comply with a court order, a court ordered warrant, or a subpoena or summons issued by an officer of the court.
Military and National Security: For example, military, lawful intelligence, counter-intelligence, and other national security activities.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

- **Your Right to Inspect and Copy Your Health Information:** To inspect and copy such information, you must submit your request in writing. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.
- **Your Right to Amend Protected Health Information:** You may request that Delta Dental change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.
- **Your Right to an Accounting of Disclosures Made by Delta Dental:** You may request an accounting of disclosures made for purposes other than treatment, payment, health care operations or made to you. You must submit your request in writing. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Delta Dental will provide the first accounting per 12-month period free of charge; we may charge you for additional reports.
- **Your Right to Request Restrictions on Uses and Disclosures:** Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.
- **Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location:** To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.
- **Your Right to a Paper Copy of this Notice:** You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.
- **Your Right to Opt Out of Fundraising Communications:** Delta Dental does not intend to contact you to raise funds, but if it does engage in fundraising, you have the right to opt-out of receiving any fund raising communications.
- **Your Right to Breach Notification:** You have the right to be notified of a breach of unsecured protected health information. Delta Dental will provide you the date and description of the information disclosed. You will be notified who the information was disclosed to if we are able. You will be notified by mail within 60 days from the date that we discover the breach.
- **Your Right to Obtain Additional Information or File a Complaint:** Send us a written request if you would like to have a more detailed explanation of these rights. Complaints about how we handle your health information should be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. Delta Dental will not retaliate against you in any way if you choose to file a complaint with us or with the department.

Genetic Information Nondiscrimination Act: Delta Dental is prohibited from using or disclosing genetic information for underwriting purposes.

Changes to this Notice

Delta Dental can amend this Notice at any time in the future and make the new Notice provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to you whenever we make significant changes. Delta Dental is required by law to comply with the current version of this Notice.

Send Written Requests Regarding this Privacy Notice to:

Privacy Officer
PO Box 5468
Denver CO 80217-5468
Or You May Call: 1-800-233-0860

TIME LIMIT ON CERTAIN DEFENSES

(a) After two years from the date of issue of this policy, the validity of this policy shall not be contested, except for non-payment of premiums, and no misstatements made by the applicant in order to acquire such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such two-year period. However, if such statement was made in writing signed by the person making the statement and a copy of that writing is presented to the maker of the statement, such statement may be used by Delta Dental to avoid the policy or reduce benefits.

(b) No claim for loss incurred after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) If this is an individual disability income insurance policy then no claim for loss incurred after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

TERMINATION/NONRENEWAL/ CONTINUATION

A Retiree's plan will terminate at the earliest of:

- The date Delta Dental of Colorado receives a written request to cancel. Coverage will end at the end of the month following notification, or at the end of the month of the life changing event. We reserve the right to recover any benefit payment made for dates of service after the terminate date.
- The date the covered person is not eligible for coverage under the terms of this policy.
- The date the benefits described in the Policy are terminated.
- When the required premium has not been paid (Subject to the applicable grace period).
- When you commit fraud or intentional misrepresentation of material facts.
- Upon the Retiree's death.

To remove a Dependent from the plan, the Retiree must notify us of the termination within 31 days. The Effective Date of the change will be the end of the month in which the change was effective. We reserve the right to recover any benefits payments made for dates of service after the termination date. Benefits for a Dependent ends on the last day of the month for the following life changing events:

- The date the benefits described in the policy are terminated.
- The date the Dependent is not eligible for coverage under the terms of this policy.
- When the Dependent child no longer qualifies as a Dependent by definition.
- When legal custody of a child placed for adoption is terminated.
- When the required premium has not been paid.
- Upon the Dependent's death.

EXTENDED COVERAGE
(Paying for Benefits after Termination)

Delta Dental benefits will end if this Policy is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service started before coverage ends, but the Covered Service is completed after coverage ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is started after coverage ends.

NONRENEWAL

This policy will automatically renew. If you don't want to renew this policy, contact Delta Dental of Colorado before the policy's renewal date. If you do not renew this policy, the policy will end on the last day before the renewal date. Delta Dental can nonrenew this policy by sending you written notice (either electronically or through the mail) at least 60 days before the renewal date. If we do, this policy will end on the last day before the renewal date.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Covered persons may be able to continue coverage through COBRA. The benefits will be the same as the benefits active Employees receive. The Covered person must pay the entire Premium, which cannot exceed 102% of the cost for an active employee with the same Plan. You should contact your employer to determine if you are able to continue coverage through COBRA.

Continued Health Coverage required by the State of Colorado

If you are not eligible for COBRA you may be eligible to continue coverage for up to 18 months under State

Continuation. Contact your employer to learn if you are eligible to continue coverage through state continuation.

APPEALS AND COMPLAINTS

Internal Appeal Process - First Level Appeals:
A Subscriber may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A Subscriber may submit additional information in support of the appeal.
Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Subscriber with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

Voluntary Second Level Appeals:
If a denial is upheld at the first level, a Subscriber may request a second level appeal. The request must be received within 30 days of the First Level Appeal decision. It must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

Additional information may be submitted. Second level appeals will be reviewed by an impartial Provider with the appropriate expertise. The reviewer will not have been involved in the first appeal. The Subscriber, or a designated representative, may request to appear before the reviewer in person or may present by conference call.

Internal Appeal Process - Expedited Appeals:
Subscribers may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Subscriber, would jeopardize the Subscriber's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

Independent External Review:
Where Delta Dental makes an Adverse Determination and the Subscriber exhausts the internal appeals process, the Subscriber has the right to request an external review. Delta Dental will notify the Subscriber of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Subscriber must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Subscriber's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Subscriber may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Subscriber, Delta Dental, the provider, and the Commissioner.

INFORMATION ON POLICY AND RATE CHANGES

If there are changes to the benefits under this plan or to the premium amount you must pay, whether due to a change in the agreement between your employer and Delta Dental or due to changes to the plan itself, your employer must provide notice to you.

If there are changes to the information provided in this document, we will issue revised materials to you.

DEFINITIONS

ALTERNATE BENEFIT means the benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the covered person selects.

BENEFITS means those Services and supplies covered pursuant to the terms of this plan. Benefits for all Covered Services are subject to the limitations and exclusions noted in this Benefit Booklet.

COINSURANCE means the percentage of a Covered Amount which is payable by Delta Dental. The Coinsurance for each type of Covered Service is shown on the Schedule of Benefits. The Coinsurance applicable will vary depending upon the type of dental Service.

COMPLETED means:

- For Root Canal Therapy: The date the canals are permanently filled.
- For Fixed bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place, regardless of the type of cement used.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

For claim payment purposes, the date Completed will be the date when a claim is incurred.

DEDUCTIBLE means the amount that must be paid by the covered person before Delta Dental will make payment. The amount of the Deductible is shown on the Schedule of Benefits. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DENTAL INJURY is an injury to a Sound Natural Tooth (other than a chewing injury) of a Covered person which results solely from a sudden, unexpected violent act or accident. A chewing injury is any injury that occurs from biting or chewing food or a foreign object.

DEPENDENT means:

- The Retiree's lawful spouse, including civil union partner, or domestic partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- Domestic partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old and view themselves as a family.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be married and may not have another partner.
  - ❖ They must have lived together for at least 6 consecutive months.
  - ❖ They must not be related.
  - ❖ They must be financially interdependent.
- A child under the Dependent Age Limit shown on the Schedule of Benefits.
- A child who reaches the Dependent Age Limit stated on the Schedule of Benefits and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Employee. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children include natural children, stepchildren, children under court-ordered guardianship, adopted children, and children of a civil union or domestic partner.

No one may be covered as a Dependent and also as a Retiree under this Plan. If both parents are covered as Retirees, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

If the Group chooses whether to cover a Civil Union Partner or a Domestic Partner that option will be noted on the Summary Page.

EFFECTIVE DATE is the date coverage begins.

EMERGENCY TREATMENT or EMERGENCY SERVICE means any required Service that is provided as the direct result of an unforeseen occurrence that requires immediate, urgent action.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those services or supplies that are not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

FUNCTIONING NATURAL TOOTH means an adult Natural Tooth which performs its normal role in chewing in the upper or lower arch and is opposed in the other arch by another Natural or artificial Tooth. Third molars are not Functioning Natural Teeth.

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount for a procedure as determined by Delta Dental.

MEMBER means any person eligible and enrolled for coverage under this plan.

NATURAL TOOTH means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

NECESSARY means a Service that is required by, and appropriate for treatment of, the Covered person's dental condition according to generally accepted standards of dental care as determined by Delta Dental.

OUT-OF-POCKET MAXIMUM means the maximum amount you will have to pay for allowable covered expenses under this plan.

POLICY means the agreement between Delta Dental and the applicant. This Policy is the whole agreement between the parties and no change is allowed unless approved by the insurer.

POLICY TERM means the time from the Effective Date of the Policy until it is terminated.

POLICY YEAR is the 365 days beginning on the Effective Date of this Policy, and each year after unless the Policy is terminated. The Policy Year is 366 days in a leap year.

PROVIDER means a person licensed to practice dentistry.

SOUND NATURAL TOOTH means a Natural Tooth that is fully restored to function, does not have any decay, is not more subject to injury than a virgin tooth, and is without periodontal disease.

STARTED means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is actually performed.
- For All Other Services: The date the Service is performed.

SUBSCRIBER means the person in whose name the membership under the policy is established.

Visit Delta Dental's Website at:
www.deltadentalco.com

You can search for a Provider, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

Delta Dental PPO Plan

Adams County Government
Group #1200 & 91200
Revised: January 1, 2020

Delta Dental PPO
Schedule of Benefits
For Group #1200 & 91200
ADAMS COUNTY GOVERNMENT

This Schedule of Benefits should be read in conjunction with your Subscriber Benefit Booklet. Your Subscriber Benefit Booklet will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **In the event that you seek treatment from a non-participating provider, you may have more out-of-pocket costs.**

Control Plan - Delta Dental of Colorado
Benefit Year - January 1st to December 31st

	PPO Provider	**Delta Dental Premier Provider**	***Non-Participating Provider**
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Sealants	100%	100%	100%
Oral Exams and Cleanings	100%	100%	100%
X-Rays	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Simple Extractions	80%	80%	80%
Complex Oral Surgery	80%	80%	80%
Basic Restorative (Fillings)	80%	80%	80%
Endodontics (Root Canal Therapy)	80%	80%	80%
Periodontics (Gum Disease Treatment)	80%	80%	80%
Major Services			
Denture Repair/Relines/Rebases	50%	50%	50%
Implants	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%
Orthodontic Services			
Orthodontics (child to age 19)	50%	50%	50%

***Important: Non-Participating Providers are allowed to balance bill. Subscribers and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month
End Dependent Ortho	19	Month

Deductible (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO and Non-PPO	$50
All Covered Classes Except D&P and Ortho	Family coverage amount	PPO and Non-PPO	$150

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO and Non-PPO	$2000
Orthodontic Classes	Individual lifetime	PPO and Non-PPO	$2000

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Subscribers may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date.

Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent. The term spouse includes a Civil Union Partner or a Domestic Partner.

Under the Delta Dental PPO plan, you may visit any Provider of your choice. There are three levels of Providers to choose from who are located nationwide:

PPO Participating Provider

Advantages of seeing a PPO Provider include:

- Payment is based upon the PPO Provider's Allowable fee, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are responsible for any applicable deductible and coinsurance for covered procedures.

You will receive the best benefits available on this plan by choosing a PPO Provider.

Premier Participating Provider (Non-PPO)
You have the option of seeing a Premier Provider, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

Non-Participating Provider (Non-PPO)
You have the option of seeing a non-participating Provider, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Provider and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.

COVERED AMOUNT means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Colorado counties without PPO or Premier Providers are Cheyenne, Crowley, Gilpin, Jackson, Kiowa, Saguache, San Juan and Sedgwick.

Delta Dental of Colorado
Group Dental Plan

CONTACT US

Visit Delta Dental's Website:
www.deltadentalco.com

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Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

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ELIGIBILITY

All eligible Subscribers and their dependents that enroll will be covered on the effective date. All Subscribers will become eligible as determined by the employer group.

This policy is effective at 12:00 a.m. on the date of enrollment and will terminate at 11:59 p.m. on the date of termination.

DEPENDENTS: For your dependents to be insured, you will have to pay the required premium for the cost of having dependents on your insurance. Your dependents will be insured only if you are insured.

No one may be covered as a Dependent and as a Subscriber under this plan. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Benefits for a Dependent Child will continue until the last day of the calendar month in which the limiting age is reached.

Persons in active military service are not eligible Dependents.

Dependents of an eligible Subscriber may enroll within 31 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the subscriber.
- New Dependents must be enrolled within 31 days and will be covered the effective date of the event. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Plan is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.
- The date upon which they lose coverage through another source, if they show proof of loss. (Loss of coverage is any loss due to death, divorce, loss of job, or termination of benefits by the subscriber). The effective date will be the date immediately following the loss of coverage date.

If not added within the 31 day timeframe, the Dependent can be added during the Open Enrollment period, if applicable.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS (Applicable to Managed Care Plans)

How to Find a Provider

There are two easy ways to find out if your Provider is a Delta Dental PPO Network Provider.

1. **Visit our website at www.deltadentalco.com** or
2. **Phone our automated call center** at 1-800-610-0201.

The network is subject to change. Please check on the status of your Provider before your next treatment.

You need not obtain approval before being treated. Before starting treatment that may cost $400 or more, you may request an estimate from Delta Dental. Pre-treatment estimates are not required.

BENEFITS/COVERAGE (What is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

Adjunctive: Certain additional Services, including emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Two exams in a 12 month period are covered. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider.
Dental Cleaning	Two cleanings in a 12 month period are covered unless documentation of special need is provided. For those with documentation, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a 12 month period. An adult cleaning is not covered for persons under age 14.
Bitewing X-rays	Covered twice in a 12 month period.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 36 month period.
Individual Periapical X-rays Intraoral Occlusal X-rays Extraoral X-rays	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children through age 15. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered once in a 12 month period for children through age 15.
Space Maintainer	Covered once per lifetime for children through age 13 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 12 months have passed since the filling was placed. Composite resin fillings on back teeth will be covered up to the cost of an amalgam filling.
Stainless Steel Crowns Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a 12 month period.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - Coronal Remnants Deciduous Tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - Erupted Tooth or Exposed Root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if the first root canal procedure on the same tooth was performed at least 24 months earlier.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings) are limited to 4 per any 12 month period.

Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.
Crown Lengthening - Hard Tissue, by Report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Surgical Extractions of Teeth or Tooth Roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.
Localized Delivery of Antimicrobial Agents	Covered once in a 24 month period. Benefit is limited to a maximum of two teeth per quadrant.

MAJOR SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

Implants: Prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prostheses.

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns, Inlays and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.
Denture Adjustments	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning per Denture Unit	Covered two times in a 36 month period.
Relining Dentures **Rebasing Dentures**	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.

Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 60 months have passed since the last placement. Not covered for children under age 12.
Crowns and Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 60 months since the last placement. Not covered for children under age 12**.**
Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Implants - Surgical Placement & Restoration	The placement of the surgical implant, and the placement of a crown, full or partial denture, or bridge over the implant, are covered once in 60 months for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Fixed Bridges	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 60 months old, is not serviceable, and cannot be repaired, and there is no prior payment of covered Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Full Dentures	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.
Temporary Removable Partial Dentures	Initial temporary removable partial dentures are covered to replace missing permanent front teeth. Replacement is covered only after 60 months have elapsed since the last placement.

ORTHODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Provider involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility. c) The initial orthodontic benefit payment for a comprehensive treatment plan of 13 months or more will be made in two (2) payments. The 1st payment will be issued at banding date or insertion. The 2nd payment will be issued 12 months later. The final payment will be reduced by any other orthodontic benefits issued that applied to the orthodontic plan maximum. Only members eligible in the Plan 12 months after initial banding or insertion will receive the final payment. d) The orthodontic payment benefit for treatment plans 12 months or less will be made in 1 payment at time of banding or insertion. This payment will be reduced by any other orthodontic benefits issued that applied to the plan's orthodontic maximum. e) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, Delta Dental will reduce periodic payments using its applicable processing polices.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a) Alternate Benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive alternate benefits.**

b) Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service.

c) Plan will pay Procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.

d) Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.

e) Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

f) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

g) The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

h) Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.

i) Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.

b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.

c) Services for treatment of birth or developmental defects, ***except*** Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate

d) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.

e) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.

f) Services resulting from improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth (splinting).

h) Habit appliances, night guards, occlusal guards, athletic mouth guards and jaw function services, bite registration or analysis, or any related services.

i) Patient management services (***except*** covered anesthetic services).

j) Charges for prescribed drugs.

k) Any Experimental or Investigational treatment.

l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.

m) Any treatment done in anticipation of future need (***except*** covered preventive services).

n) Hospital costs or any charges for use of any facility.

o) Any anesthesia service not included in Covered Services.

p) Grafts done in the mouth where teeth are not present.

q) Grafts of tissues from outside the mouth into the mouth.

r) Therapy for speech or the function of the tongue or face.

s) Orthodontic Services unless shown as covered on the Schedule of Benefits.

t) Implant Services unless shown as covered on the Schedule of Benefits.

u) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.

v) Services not performed in accordance with Colorado state law. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.

w) Teaching services.

x) Completion of forms. Providing diagnostic information. Copying of other records.

y) Replacement of lost, stolen or damaged items.

z) Repair of items altered by someone other than a Provider.

aa) Any Services not included in Covered Services.

bb) Services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid.
cc) Missed appointment charges.
dd) Preventive control programs, including home care items.
ee) Plaque control programs.
ff) Self-injury.
gg) Provisional splinting.
hh) Bone grafting when done in the same site as a tooth extraction, apicoectomy or hemisection.
ii) Services provided for treatment of teeth retained in relation to an Overdenture.
jj) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
kk) Any Special Restorative service provided within 60 months of fixed Prosthodontic services involving the same teeth.
ll) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.

MEMBER PAYMENTS RESPONSIBILITY

You must pay deductibles, amounts above the annual maximum, amounts up to the out-of-pocket maximum, and your coinsurance. You must pay charges for Services not covered under this plan. You may be responsible for some part of the premium.

CLAIM PROCEDURES (How to File a Claim)

If you are covered by more than one dental plan, you should file all of your claims with each plan.

Delta Dental will not pay claims submitted more than 12 months after the date of service.

PRE-TREATMENT ESTIMATE

Before starting treatment that may cost $400 or more, you may request an estimate of what is covered. Pre-treatment estimates are not required.

RIGHT TO EXAMINATION

Delta Dental shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy.

GENERAL POLICY PROVISIONS

AGREEMENT WITH STATE LAW

Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Covered Person lives is hereby changed to the minimum requirement of such laws.

ASSIGNMENT OF BENEFITS

You may assign any benefits of this policy to your dental provider. You may revoke this assignment at any time by sending a written revocation to Delta Dental.

NON-DISCRIMINATION

With regard to participation in its networks, Delta Dental does not discriminate against any provider acting in the scope of his or her license.

COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits. For the complete listing of your policy's coordination of benefits provisions, please contact your group plan administrator or the state Division of Insurance.

Double Coverage

Family members may be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your group plan administrator or your state insurance department for a full review of coordination of benefits requirements.

Primary or Secondary?
You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary.

When This Plan is Primary
If you or a family member are covered under another plan in addition to this one, Delta Dental will be primary when:

Your Own Expenses
▪The claim is for your own health care expenses, unless you are covered by Medicare Advantage and both you and your spouse are retired.

Your Own Expenses
▪The claim is for your own health care.

Your Child's Expenses
▪The claim is for the health care expenses of your child who is covered by this plan and

▪you are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";
or
▪you are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses;
or
▪there is no court decree, but you have primary custody of the child.

Other Situations
We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary
When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary
We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

▪If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the contract calls for Health maintenance organizations (HMO) and preferred Provider organizations (PPO) usually have contracts with their Providers.

▪We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

▪If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we may pay for those expenses. We will not pay an amount the primary plan did not cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions about Coordination of Benefits?

Colorado Division of Insurance
1560 Broadway, Ste 850
Denver, CO 80202
Phone Number: 303-894-7490 or 1-800-930-3745

SUBROGATION

Delta Dental has the right to enforce on its own, or with a covered person, a claim against a third party up to the amount paid by Delta Dental. If Delta Dental pays a claim for injuries to a covered person and the covered person settles with a third party for an amount that includes such costs, the covered person must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the covered person.

HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, your employer has agreed to:

a) Not use or disclose health information other than as permitted or as required by law.
b) Ensure that any agents who receive protected health information (PHI) agree to the same restrictions that apply to your employer.
c) Not use or disclose PHI for employment actions and decisions.
d) Report to the Plan any improper use or disclosure of PHI that they are aware of.

e) Make PHI available for your own use and provide you with the right to amend or correct your own PHI upon request.
f) Provide an accounting of its disclosures to individuals and make its practices relating to the use or disclosure of PHI available to the Secretary of HHS.
g) Ensure that there is separation between the Plan and the Plan Sponsor as required by HIPAA. Ensure that there are reasonable security controls.
h) If possible, return or destroy all PHI received from the Plan when no longer needed.
i) Implement safeguards that protect electronic PHI that is managed on behalf of the group health plan.
j) Ensure that any agent to whom it provides electronic PHI agrees to implement security measures to protect the information.
k) Report to the group health plan any security incident of which it becomes aware.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access this information.

Delta Dental is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information. This notice is effective on the date your group coverage went into effect.

How We May Use and Disclose Health Information About You
In almost all cases, we may use and disclose protected health information for treatment, payment, and health care operations. For example, we may use and disclose protected health information:

1. To communicate with the provider who provides, coordinates, or manages your care,
2. To determine how much or whom we should pay for covered services,
3. To assess the quality of care that our participating providers provide.

Other categories describing how we may use and disclose your health information are listed below, along with some examples of these uses and disclosures.

To You and With Your Written Authorization: We may disclose your health information to you in the manner and for the purposes described in the "Your Rights" section of this Notice. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your prior authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information to any person or for any reason not permitted by law.

An authorization is required for uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information. Any other uses and disclosures not specifically described in this notice will be made only with the individual's authorization.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person if you provide us written authorization to do so.

Disclosure to Plan Sponsors: For example, to help the sponsor of your group health plan administer your benefits.

Health Related Benefits and Services: We may use or disclose health information about you to communicate to you about health-related benefits and services.

Research: We may use or disclose health information about you for research purposes. If we do, Delta Dental may be required to obtain an authorization from you for such use or disclosure.

Public Health and Safety: For example, to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Required by Law: For example, as required by federal or state statute or regulation, worker's compensation or similar laws and state insurance and health regulatory authorities.

Lawsuits and Disputes: For example, in the course of any administrative or judicial proceeding.

Law Enforcement: For example, to identify or locate a suspect or to comply with a court order, a court ordered warrant, or a subpoena or summons issued by an officer of the court.

Military and National Security: For example, military, lawful intelligence, counter-intelligence, and other national security activities.

Your Rights Regarding Health Information About You
You have the following rights regarding health information we maintain about you:

- **Your Right to Inspect and Copy Your Health Information:** To inspect and copy such information, you must submit your request in writing. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.
- **Your Right to Amend Protected Health Information:** You may request that Delta Dental change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

- **Your Right to an Accounting of Disclosures Made by Delta Dental:** You may request an accounting of disclosures made for purposes other than treatment, payment, health care operations or made to you. You must submit your request in writing. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Delta Dental will provide the first accounting per 12-month period free of charge; we may charge you for additional reports.
- **Your Right to Request Restrictions on Uses and Disclosures:** Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.
- **Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location:** To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.
- **Your Right to a Paper Copy of this Notice:** You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.
- **Your Right to Opt Out of Fundraising Communications:** Delta Dental does not intend to contact you to raise funds, but if it does engage in fundraising, you have the right to opt-out of receiving any fund raising communications.
- **Your Right to Breach Notification:** You have the right to be notified of a breach of unsecured protected health information. Delta Dental will provide you the date and description of the information disclosed. You will be notified who the information was disclosed to if we are able. You will be notified by mail within 60 days from the date that we discover the breach.
- **Your Right to Obtain Additional Information or File a Complaint:** Send us a written request if you would like to have a more detailed explanation of these rights. Complaints about how we handle your health information should be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. Delta Dental will not retaliate against you in any way if you choose to file a complaint with us or with the department.

Genetic Information Nondiscrimination Act: Delta Dental is prohibited from using or disclosing genetic information for underwriting purposes.

Changes to this Notice

Delta Dental can amend this Notice at any time in the future and make the new Notice provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to you whenever we make significant changes. Delta Dental is required by law to comply with the current version of this Notice.

Send Written Requests Regarding this Privacy Notice to:

Privacy Officer
PO Box 5468
Denver CO 80217-5468
Or You May Call: 1-800-233-0860

TIME LIMIT ON CERTAIN DEFENSES

(a) After two years from the date of issue of this policy, the validity of this policy shall not be contested, except for non-payment of premiums, and no misstatements made by the applicant in order to acquire such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such two-year period. However, if such statement was made in writing signed by the person making the statement and a copy of that writing is presented to the maker of the statement, such statement may be used by Delta Dental to avoid the policy or reduce benefits.

(b) No claim for loss incurred after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) If this is an individual disability income insurance policy then no claim for loss incurred after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

TERMINATION/NONRENEWAL/ CONTINUATION

A Subscriber's plan will terminate at the earliest of:

- The date Delta Dental of Colorado receives a written request to cancel. Coverage will end at the end of the month following notification, or at the end of the month of the life changing event. We reserve the right to recover any benefit payment made for dates of service after the terminate date.
- The date the Subscriber is not eligible for coverage under the terms of this policy.
- The date the benefits described in the Policy are terminated.
- When the required premium has not been paid (Subject to the applicable grace period).
- When you commit fraud or intentional misrepresentation of material facts.
- For the Subscriber, 12 months from the date the member enters active military service.
- For Dependents, the end of the month following active military service.
- Upon the Subscriber's death.

To remove a Dependent from the plan, the Subscriber must notify us of the termination within 31 days. The Effective Date of the change will be the end of the month in which the change was effective. We reserve the right to recover any benefits payments made for dates of service after the termination date.

Benefits for a Dependent ends on the last day of the month for the following life changing events:

- The date the benefits described in the policy are terminated.
- The date the Dependent is not eligible for coverage under the terms of this policy.
- When the Dependent child no longer qualifies as a Dependent by definition.
- When legal custody of a child placed for adoption is terminated.
- When the required premium has not been paid.
- Upon the Dependent's death.

EXTENDED COVERAGE
(Paying for Benefits after Termination)

Delta Dental benefits will end if this Policy is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service started before coverage ends, but the Covered Service is completed after coverage ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is started after coverage ends.

NONRENEWAL

This policy will automatically renew. If you don't want to renew this policy, contact Delta Dental of Colorado before the policy's renewal date. If you do not renew this policy, the policy will end on the last day before the renewal date. Delta Dental can nonrenew this policy by sending you written notice (either electronically or through the mail) at least 60 days before the renewal dates. If we do, this policy will end on the last day before the renewal date.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Covered persons may be able to continue coverage through COBRA. The benefits will be the same as the benefits active Subscribers receive. The Covered person must pay the entire Premium, which cannot exceed 102% of the cost for an active Subscriber with the same Plan. You should contact your employer to determine if you are able to continue coverage through COBRA.

Continued Health Coverage required by the State of Colorado

If you are not eligible for COBRA you may be eligible to continue coverage for up to 18 months under State Continuation. Contact your employer to learn if you are eligible to continue coverage through state continuation.

APPEALS AND COMPLAINTS

Internal Appeal Process - First Level Appeals:

A Subscriber may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A Subscriber may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Subscriber with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

Internal Appeal Process - Expedited Appeals:
Subscribers may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Subscriber, would jeopardize the Subscriber's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

Independent External Review:
Where Delta Dental makes an Adverse Determination and the Subscriber exhausts the internal appeals process, the Subscriber has the right to request an external review. Delta Dental will notify the Subscriber of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Subscriber must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Subscriber's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Subscriber may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Subscriber, Delta Dental, the provider, and the Commissioner.

INFORMATION ON POLICY AND RATE CHANGES

No change in your policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed on the policy. No agent has authority to change this policy or to waive any of its provisions except where approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer. Any such amendment that reduces or eliminates coverage shall have been either requested in writing or signed by your Employer.

If there are changes to the information provided in this document, we will issue revised materials to you.

DEFINITIONS

ALTERNATE BENEFIT means the benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the covered person selects.

BENEFITS means those Services and supplies covered pursuant to the terms of this plan. Benefits for all Covered Services are subject to the limitations and exclusions noted in this Benefit Booklet.

COINSURANCE means the percentage of a Covered Amount which is payable by Delta Dental. The Coinsurance for each type of Covered Service is shown on the Schedule of Benefits. The Coinsurance applicable will vary depending upon the type of dental Service.

COMPLETED means:

- For Root Canal Therapy: The date the canals are permanently filled.
- For Fixed bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place, regardless of the type of cement used.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

For claim payment purposes, the date Completed will be the date when a claim is incurred.

DEDUCTIBLE means the amount that must be paid by the covered person before Delta Dental will make payment. The amount of the Deductible is shown on the Schedule of Benefits. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DENTAL INJURY is an injury to a Sound Natural Tooth (other than a chewing injury) of a Covered person which results solely from a sudden, unexpected violent act or accident. A chewing injury is any injury that occurs from biting or chewing food or a foreign object.

DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner, or domestic partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- Domestic partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old and view themselves as a family.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be married and may not have another partner.
  - ❖ They must have lived together for at least 6 consecutive months.
  - ❖ They must not be related.
  - ❖ They must be financially interdependent.
- A child under the Dependent Age Limit shown on the Schedule of Benefits.
- A child who reaches the Dependent Age Limit stated on the Schedule of Benefits and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children include natural children, stepchildren, children under court-ordered guardianship, adopted children, and children of a civil union or domestic partner.

No one may be covered as a Dependent and also as a Subscriber under this Plan. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

EFFECTIVE DATE is the date coverage begins

EMERGENCY TREATMENT or EMERGENCY SERVICE means any required Service that is provided as the direct result of an unforeseen occurrence that requires immediate, urgent action.

EMPLOYEE means someone who works the minimum number of hours as defined by the employer.

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount for a procedure as determined by Delta Dental.

MEMBER means any person eligible and enrolled for coverage under this plan.

NECESSARY means a Service that is required by, and appropriate for treatment of, the Covered person's dental condition according to generally accepted standards of dental care as determined by Delta Dental.

OUT-OF-POCKET MAXIMUM means the maximum amount you will have to pay for allowable covered expenses under this plan.

POLICY means the agreement between Delta Dental and the applicant. This Policy is the whole agreement between the parties and no change is allowed unless approved by the insurer.

POLICY TERM means the time from the Effective Date of the Policy until it is terminated.

POLICY YEAR is the 365 days beginning on the Effective Date of this Policy, and each year after unless the Policy is terminated. The Policy Year is 366 days in a leap year.

PROVIDER means a person licensed to practice dentistry.

STARTED means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is actually performed.
- For All Other Services: The date the Service is performed.

SUBSCRIBER means the person in whose name the membership under the policy is established. A person who elects continued coverage and for whom the monthly Premium is paid.

Visit Delta Dental's Website at:
www.deltadentalco.com

You can search for a Provider, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: 2020 Group Agreement with Kaiser Permanente
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: October 15, 2019
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approve the 2020 Group Agreement with Kaiser Permanente.

BACKGROUND: The Adams County Board of County Commissioners entered into a contract with Kaiser Permanente in 1981 to provide a quality health care plan to Adams County employees and retirees and continues to offer this option in 2020, thereby providing additional health plan choices.

The attached Group Agreements, Amendments, Letters of Understanding, Rate Sheets and Evidences of Coverage outline the current benefits with Kaiser Permanente as approved through Study Session.

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

ATTACHED DOCUMENTS:
2020 Evidence of Coverage
2020 Medicare Evidence of Coverage
2020 Large Group Agreement
January 1, 2020 Letter of Understanding

January 1, 2020 Letter of Agreement: Late Enrollment Penalty
Amendment One 2020 Group Agreement Eligibility and Miscellaneous Provisions
Amendment Two 2020 Group Agreement Medicare Low Income Subsidy (LIS)
Amendment Three 2020 Group Agreement Senior Advantage Medicare
2020 ADCO Rate Sheet

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8615

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	Various		
Add'l Operating Expenditure not included in Current Budget:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

KAISER PERMANENTE®

January 1, 2020

County of Adams
4430 S. Adams County Parkway, Suite C4000B
Brighton, Colorado 80601

Subject: Late Enrollment Penalty

Dear County of Adams:

The purpose of this letter is to acknowledge that you have requested Kaiser Foundation Health Plan of Colorado ("Health Plan") to collect any Late Enrollment Penalties that may be assessed by the Centers for Medicare & Medicaid Services (CMS) for your retirees and their dependents ("Members") who did not sign up for Medicare Part D prescription drug coverage when they were first eligible.

Starting January 1, 2020 and for the duration of your 2020 Plan Year, Health Plan will bill Members directly on a monthly basis if they owe a Late Enrollment Penalty. We will bill only for the amount of their Late Enrollment Penalty each month. An explanation of the Late Enrollment Penalty, along with instructions to contact Health Plan with questions or concerns, will be included with each month's statement. We will continue to bill the Members for the Late Enrollment Penalty during the Plan Year for as long as they remain enrolled in the Kaiser Permanente Senior Advantage coverage that you have purchased.

Please note that pursuant to federal guidelines, we may disenroll individuals for nonpayment of the Late Enrollment Penalty, consistent with our disenrollment policies for nonpayment of premium.

Your agreement with Health Plan indicates that we will increase your Premiums by the amount of the Late Enrollment Penalty owed by your Members. However, due to your request that we bill your Members directly, this acknowledgement letter hereby supersedes that provision. Accordingly, by this letter you acknowledge that the Group Agreement between Health Plan and County of Adams for the Plan Year January 1, 2020, is hereby amended as follows:

The following provision in the Section "Late Enrollment Penalty" is hereby deleted in its entirety:

> *If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of the penalty.*

To confirm your acceptance of the terms of this letter, please sign and date a copy of this letter.

Please contact your Health Plan Account Manager if you have questions about the Late Enrollment Penalty or the information in this letter.

Thank you.

Kaiser Permanente
Account Management

THE ABOVE TERMS ARE UNDERSTOOD AND AGREED TO:

County of Adams
By: _____
Name: _____
Title: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

KAISER PERMANENTE®

January 1, 2020

County of Adams

Re: Letter of Understanding between County of Adams and Kaiser Foundation Health Plan of Colorado

Dear Group Administrator:

This is a Letter of Understanding between County of Adams (County) and Kaiser Foundation Health Plan of Colorado (Health Plan) regarding County's request to change various time frames in the 2020 Group Agreement as follows:

Amendments Effective on an Anniversary Date
County requested and Health Plan agreed to provide 60 days written notice to County with respect to any rate changes that will become effective on the Anniversary Date as shown on the Rate Sheet.

Time Limit on Reporting Membership Changes
Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accordance with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership **additions and terminations** is the calendar month when Health Plan receives Group's notification of the change plus the previous two months, unless Health Plan agrees otherwise in writing.

Other Amendments
County requested and Health Plan agreed to align modification of the County's Service Area with their renewal.

Termination of Agreement
County requested and Health Plan agreed to allow County 30 days to mail each Subscriber a legible copy of the notice to terminate.

Termination for Nonpayment
County requested and Health Plan agreed to allow County to pay dues 14 days after the 31-day grace period for a total of 45 days.

Termination for Movement Outside the Service Area
County requested and Health Plan agreed Health Plan will provide County with 60 days written notice of termination if no eligible person lives, resides, or works in Health Plan's Service Area.

Termination for Violation of Contribution or Participation Requirements
County requested, and Health Plan agreed to provide 60 days advanced written notice to County prior to termination of the Agreement.

Termination for Fraud or for Intentionally Furnishing Incorrect or Incomplete Information
County requested, and Health Plan agreed to provide 60 days advanced written notice to County prior to termination of the Agreement.

Contribution and Participation Requirements
County request and Health Plan agreed County's contribution will be no less than $50 for a single Subscriber.

Please call **303-306-2686** if you have questions about this Letter of Understanding. Otherwise, please indicate your agreement by signing and dating where indicated below and returning a signed copy to me.

Sincerely,
Benefit, Policy and Contract Administration
2530 South Parker Road – Third Floor
Aurora, CO 80014

AGREED TO:
County of Adams

By: _____
Signature of Authorized Group Representative

_____
Title

Date: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

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

WHEREAS, the Adams County Board of County Commissioners recognize the importance of providing quality health insurance plans with variable options for county employees at a reasonable cost; and,

WHEREAS, Adams County has had an agreement with Kaiser Permanente since January 1, 1981 to provide a quality health care plan to Adams County employees and their families; and,

WHEREAS, the Adams County Board of County Commissioners intends to continue to contract with Kaiser Permanente for the provision of quality health care for Adams County employees and their families, thereby providing additional health plan choices at a reasonable cost; and,

WHEREAS, the attached documents constitute the Amendments to Adams County's agreement with Kaiser Permanente for the provision of health care to Adams County employees and will remain in effect through December 31, 2020:

1. 2020 Evidence of Coverage
2. 2020 Medicare Evidence of Coverage
3. 2020 Large Group Agreement
4. January 1, 2020 Letter of Understanding
5. January 1, 2020 Letter of Agreement: Late Enrollment Penalty
6. Amendment One 2020 Group Agreement Eligibility and Miscellaneous Provisions
7. Amendment Two 2020 Group Agreement Medicare Low Income Subsidy (LIS)
8. Amendment Three 2020 Group Agreement Senior Advantage Medicare
9. 2020 ADCO Rate Sheet

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

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

Group Name: COUNTY OF ADAMS

Group Number: 385

Contract Period: 01/01/2020 - 12/31/2020

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
001	COUNTY OF ADAMS	Non Medicare	EMBC	$15 OVC HMO M NGF
003	COUNTY OF ADAMS - COBRA	Non Medicare	EMBC	$15 OVC HMO M NGF
005	COUNTY OF ADAMS EDC	Non Medicare	EMBC	$15 OVC HMO M NGF
007	COUNTY OF ADAMS ACTIVES NC	Non Medicare	EMBC	$15 OVC HMO M NGF
009	COUNTY OF ADAMS- COBRA NC	Non Medicare	EMBC	$15 OVC HMO M NGF
011	COUNTY OF ADAMS EDC NC	Non Medicare	EMBC	$15 OVC HMO M NGF

Steps	Total
Employee Only	$667.04
Spouse Only	$667.04
Child Only	$667.04
Employee & Spouse	$1,400.78
Employee & Child	$1,400.78
Spouse & Child	$1,400.78
Children Only (CK)	$1,400.78
Employee, Spouse & Child/Children	$2,014.53
Employee & Children (ECK+)	$2,014.53
Spouse & Children (SCK+)	$2,014.53
Children Only (CKK+)	$2,014.53

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: COUNTY OF ADAMS

Group Number: 385

Contract Period: 01/01/2020 - 12/31/2020

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
001	COUNTY OF ADAMS	Medicare	EMBC	$15 OVC HMO M NGF
003	COUNTY OF ADAMS - COBRA	Medicare	EMBC	$15 OVC HMO M NGF
005	COUNTY OF ADAMS EDC	Medicare	EMBC	$15 OVC HMO M NGF
007	COUNTY OF ADAMS ACTIVES NC	Medicare	EMBC	$15 OVC HMO M NGF
009	COUNTY OF ADAMS- COBRA NC	Medicare	EMBC	$15 OVC HMO M NGF
011	COUNTY OF ADAMS EDC NC	Medicare	EMBC	$15 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	$237.33
Medicare Risk B	$628.59
Medicare Risk BD	$628.59
Medicare Risk CD	$237.33

Group Name: COUNTY OF ADAMS

Group Number: 385 Contract Period: 01/01/2020 - 12/31/2020

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
002	COUNTY OF ADAMS RETIREES	Non Medicare	EMBC	$15 OVC HMO M NGF
004	CO OF ADAMS EARLY RETIREES COB	Non Medicare	EMBC	$15 OVC HMO M NGF
008	COUNTY OF ADAMS RETIREE NC	Non Medicare	EMBC	$15 OVC HMO M NGF
010	COUNTY OF ADAMS EARLY RT NC	Non Medicare	EMBC	$15 OVC HMO M NGF

Steps	Total
Employee Only	$718.14
Spouse Only	$718.14
Child Only	$718.14
Employee & Spouse	$1,508.08
Employee & Child	$1,508.08
Spouse & Child	$1,508.08
Children Only (CK)	$1,508.08
Employee, Spouse & Child/Children	$2,168.70
Employee & Children (ECK+)	$2,168.70
Spouse & Children (SCK+)	$2,168.70
Children Only (CKK+)	$2,168.70

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: COUNTY OF ADAMS

Group Number: 385 Contract Period: 01/01/2020 - 12/31/2020

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
002	COUNTY OF ADAMS RETIREES	Medicare	EMBC	$15 OVC HMO M NGF
004	CO OF ADAMS EARLY RETIREES COB	Medicare	EMBC	$15 OVC HMO M NGF
008	COUNTY OF ADAMS RETIREE NC	Medicare	EMBC	$15 OVC HMO M NGF
010	COUNTY OF ADAMS EARLY RT NC	Medicare	EMBC	$15 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	$237.33
Medicare Risk B	$628.59
Medicare Risk BD	$628.59
Medicare Risk CD	$237.33

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Kaiser Permanente," "Kaiser," "Health Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2020 contract year.

kp.org

KAISER PERMANENTE®

NONDISCRIMINATION NOTICE

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

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

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

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

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

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

HELP IN YOUR LANGUAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

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

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

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

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

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

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

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in a non-Plan Facility, or Services rendered by a non-Plan Provider in a Plan Facility, you will not be balance billed by either the non-Plan Provider or non-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

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

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

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

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

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

II. ANNUAL OUT-OF-POCKET MAXIMUMS

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

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

   1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
   2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit Copayment may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance with $250 maximum
• Travel immunizations *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a doctor online via kp.org	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	Ambulatory surgical center: $150 Copayment each surgery Outpatient hospital: $300 Copayment each surgery

Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	**You Pay**
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

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

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

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and non-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see “X-ray, Laboratory, and X-ray Special Procedures” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)* Covered only if <u>all</u> the following requirements are met: • The care is required to prevent serious decline of health • The need for care results from an unforeseen illness or injury when temporarily away from our Service Area • The care cannot be delayed until you return to our Service Area	$50 Copayment each visit Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.

Family Planning and Sterilization Services	You Pay
Family planning counseling *(See "Office Services" for Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for Out-of-Pocket Maximum information).*	See "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	You Pay
Training in self-care and preventive care *(See "Office Services" for Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Physician *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

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

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$15 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$15 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) (*Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit

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

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

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

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

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services (formerly Chemical Dependency Services)	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per admission

Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per inpatient admission

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

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Test: $15 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Test: $15 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit Test: $25 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit Test: $25 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

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

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

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

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week	
CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**: 970-207-7171** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health	
CALL	***Denver/Boulder*** Members: **303-471-7700** ***Southern Colorado*** Members: **1-866-702-9026** ***Northern Colorado*** Members: **1-866-359-8299**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services	
CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-844-201-5824**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	***Denver/Boulder*** Members: **303-338-3600** or toll-free **1-800-382-4661** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	***Denver/Boulder*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Southern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 372910** **Denver, CO 80237-6910** ***Northern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Patient Financial Services	
CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-844-201-5824**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Personal Physician Selection Services	
CALL	***Denver/Boulder*** Members: **303-338-4477** ***Southern Colorado*** Members: **1-855-208-7221** ***Northern Colorado*** Members**: 1-855-208-7221**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**kp.org/locations** for a list of providers and facilities

Transplant Administrative Offices	
CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General
   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers
   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents
   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)
   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."
   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.
   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

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

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

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

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

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
      For existing Subscribers:

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

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

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

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

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

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

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

5. Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside your home Service Area, except as described under the following headings:

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

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the "Using Your Health Plan Identification Card" section.

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

Note: ***Denver/Boulder*** Members do not have access to Affiliated Providers within the ***Denver/Boulder*** Service Area unless authorized by Health Plan. ***Southern*** and ***Northern Colorado*** Members do have access to Affiliated Providers within their home Service Area.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine within your home Service Area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section.

   a. ***Denver/Boulder*** Service Area

      You may choose your PCP from our provider directory. To review a list of Plan Providers and their biographies, visit our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign in to your account online or call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

   b. ***Southern*** and ***Northern Colorado*** Service Areas

      You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

      Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the ***Southern*** and ***Northern Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern*** and ***Northern Colorado*** providers.

      You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of ***Southern*** and ***Northern Colorado*** Plan Providers by visiting our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

      If you are seeking routine or specialty care in ***Denver/Boulder***, you must have a referral from your local PCP with an Authorization from Health Plan. If you do not have an Authorization, you will be billed for the full amount of the office visit Charges. If you are visiting in the ***Denver/Boulder*** Service Area and need urgent or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For a referral from a specialist, see the "Access to Other Providers" section. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access".

2. Changing Your Primary Care Provider

   a. ***Denver/Boulder*** Service Area

      Please call **Personal Physician Selection Services** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

   b. ***Southern*** and ***Northern Colorado*** Service Areas

      Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Access to Other Providers

1. Referrals and Authorizations

   a. ***Denver/Boulder*** Service Area

      If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

      An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the

Authorization is valid. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized by Health Plan and approved in advance. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

b. ***Southern*** and ***Northern Colorado*** Service Areas

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized by Health Plan and approved in advance. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Self-Referrals

a. ***Denver/Boulder*** Service Area

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

b. ***Southern*** and ***Northern Colorado*** Service Areas

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

Southern and ***Northern Colorado*** Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access" in this section).

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

   If the recommendations of the first and second physician differ regarding the need for surgery (or other major procedure), a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

C. Plan Facilities

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. ***Denver/Boulder*** Service Area
   We offer health care at Plan Medical Offices conveniently located throughout the ***Denver/Boulder*** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home Service Area that will be most convenient for you.

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

2. ***Southern*** and ***Northern Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that provider's office. You can find ***Southern*** and ***Northern Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at a non-Plan Facility inside your Service Area is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside your Service Area, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside your Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and

Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, and/or Coinsurance, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

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

F. Moving Outside of our Service Area

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

G. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

H. Cross Market Access

Members may access certain Services at Kaiser Permanente Colorado Plan Medical Offices outside of their home Service Area.

1. ***Denver/Boulder*** Members
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the ***Southern*** and ***Northern Colorado*** Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern*** and ***Northern Colorado*** unless authorized by Health Plan.

2. ***Southern*** and ***Northern Colorado*** Members
   Southern and ***Northern Colorado*** Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder, Southern,*** and ***Northern Colorado*** Service Areas. ***Southern*** and ***Northern Colorado*** Members do not have access to Affiliated Providers outside their home Service Area unless authorized by Health Plan.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; urgent care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Kaiser Permanente Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which Kaiser Permanente Plan Medical Offices you may receive Services please call **Member Services**.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where specifically noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and

- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. Second opinion.
9. House calls when care can best be provided in your home as determined by a Plan Physician.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs.

    Note: If the following are administered in a Plan Medical Office or during home visits, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to your Office Services Copayment or Coinsurance.

    Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

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

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

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

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for child birth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

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

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

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

E. Clinical Trials

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

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:

   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.

d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   iii. The study or investigation is approved or funded by at least one of the following:
      (a) The National Institutes of Health.
      (b) The Centers for Disease Control and Prevention.
      (c) The Agency for Health Care Research and Quality.
      (d) The Centers for Medicare & Medicaid Services.
      (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
      (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
         (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
         (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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

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

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Health Plan; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover at no Charge: equipment; training; and medical supplies required for home dialysis.

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

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.

iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

b. Durable Medical Equipment Exclusions
   i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
   ii. Replacement of lost or stolen equipment.
   iii. Repair, adjustments, or replacements necessitated by misuse.
   iv. Spare equipment or alternate use equipment.
   v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
   We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

   Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
   Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

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

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

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

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

I. Emergency Services and Urgent Care

1. Emergency Services

Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers. For information about emergency benefits away from home, please call **Member Services**.

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

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

a. Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)

"Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

Please refer to "ii. Emergency Services Limitation for non-Plan Providers" if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:

A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility, only if a prudent layperson having average knowledge of health services and medicine and acting reasonably would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for treatment would result in death or serious impairment of health.

ii. Emergency Services Limitation for non-Plan Providers

If you are admitted to a non-Plan Hospital, non-Plan Facility, or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to a non-Plan Hospital, non-Plan Facility, or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible.

b. Emergency Services Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

c. Payment

Our payment is reduced by:

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

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

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

2. Urgent Care
   a. Urgent Care Provided by Plan Providers
      i. ***Denver/Boulder*** Service Area

      Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

      Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)". For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

      You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

      ii. ***Southern*** and ***Northern Colorado*** Service Areas

      Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

      Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)". For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

      You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

   b. Urgent Care Outside the Service Area

   There may be situations when it is necessary for you to receive unauthorized urgent care outside your Service Area. Urgent care received from non-Plan Providers outside your Service Area is covered only if all of the following requirements are met:
      i. The care is required to prevent serious deterioration of your health; and
      ii. The need for care results from an unforeseen illness or injury when you are temporarily away from our Service Area; and
      iii. The care cannot be delayed until you return to our Service Area.

   Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

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

J. Family Planning and Sterilization Services

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

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

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

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

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18

   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage

   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Physician and either self-administered or administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
   d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)".

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Care that Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

We cover hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

We cover the following Services and other benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

a. Physician care.

b. Nursing care.

c. Physical, occupational, speech, and respiratory therapy.

d. Medical social Services.

e. Home health aide and homemaker Services.

f. Medical supplies, drugs, biologicals, and appliances.

g. Palliative drugs in accordance with our drug formulary guidelines.

h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.

i. Counseling and bereavement Services.

j. Services of volunteers.

O. Mental Health Services

1. Coverage

We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

a. Outpatient Therapy

We cover: diagnostic evaluation; individual therapy; intensive outpatient therapy; psychiatric treatment; crisis intervention and stabilization for acute episodes; and psychiatrically oriented child and teenage guidance counseling.

Visits for the purpose of monitoring drug therapy are covered.

Psychological testing as part of diagnostic evaluation is covered.

b. Inpatient Services

We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

c. Partial Hospitalization

We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions

a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
b. Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
c. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

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

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

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

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

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)".
   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."
   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We also cover multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."
   d. Pulmonary Rehabilitation
      Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.
   e. Therapies for Congenital Defects and Birth Abnormalities
      After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth

abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Physician and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Plan Medical Office or other location approved by Health Plan. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use drug formularies. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees for our Members. Our committees are comprised of Plan Physicians, pharmacists, and a nurse practitioner. The committees select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)".

   Note: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

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

the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or

(b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

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

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

b. Outpatient Prescription Drugs

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

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements

We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories

Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

i. home glucose monitoring supplies;
ii. disposable syringes for the administration of insulin;
iii. glucose test strips;
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations

a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.

b. Some drugs may require prior authorization.

c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request an exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions

a. Drugs for which a prescription is not required by law.
b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
d. Any packaging except the dispensing pharmacy's standard packaging.

e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions".
g. Drugs to shorten the length of the common cold.
h. Drugs to enhance athletic performance.
i. Drugs for the treatment of weight control.
j. Drugs available over the counter and by prescription for the same strength.
k. Individual drugs determined excluded by our Pharmacy and Therapeutics Committee.
l. Unless approved by Health Plan, drugs not approved by the FDA.
m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
n. Prescription drugs necessary for Services excluded under this EOC.
o. Drugs administered during a medical office visit. See "Office Services".
p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

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

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

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

T. Reconstructive Surgery

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

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

U. Reproductive Support Services

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

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

V. Skilled Nursing Facility Care

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

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

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

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

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered the same way as any other medical condition. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Physician.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Physician.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

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

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)". For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

   b. Plan Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage

   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)". We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   e. Orthoptic (eye training) therapy or low vision therapy.

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

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient

      We cover the following Services:

      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

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

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

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

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

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

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

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

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

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

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

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

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

7. **Directed Blood Donations.**

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

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

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

11. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

   d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

   Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.

13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when Medical Group refers you to a non-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.
   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
   iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
   iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment

arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

ORDER-OF-BENEFIT DETERMINATION RULES

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

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

b.

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

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

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

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

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

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

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

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

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

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;

3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

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

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

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

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

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

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

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

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian or conservator and any settlement or judgment recovered by the estate, parent, guardian or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

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

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

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

You must send this information to:

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

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by non-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

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

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

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the *Notice of Privacy Practices* on our website at kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date on which your Group coverage would otherwise terminate.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Copayments and Coinsurance may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

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

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

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative

If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim
      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

      If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We

may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

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

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an

appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

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

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

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

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

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

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

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

a. Post-Service Claim

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

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

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

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

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

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

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

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

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

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that

you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department

of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Medical Office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Physician evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Physicians. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

Affiliated Provider: A health care provider that we designate as an Affiliated Provider.

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

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

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

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:

1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Family Unit: A Subscriber and all of his or her Dependents.

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: Health Plan and Medical Group.

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

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:

- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan or non-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory, including any outpatient facility designated by Health Plan. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician, or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Premiums: Periodic membership charges paid by Group.

Service Area:
The ***Denver/Boulder*** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller, and Weld counties within the following zip codes: 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80640, 80642, 80643.

The ***Northern Colorado*** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82070, 82082.

The ***Southern Colorado*** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo, and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

ELECTIVE ABORTION EXCLUSION

Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are:

1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or
2. When the pregnancy is the result of an act of rape or incest; or
3. Treatment of complications following an abortion.

TABS0AA (01-12)

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for both same- and opposite-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same- and opposite-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMPA0AA (01-18)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Spouse and eligible Dependent children may continue coverage in the Group, if they wish.

SRDC0AK (01-08)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

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

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

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

   You may self-refer for visits to contracted providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

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

CHIR0AA (01-18)
DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

   c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
iii. Non-medical items such as sauna baths or elevators.
iv. Exercise or hygiene equipment.
v. Comfort, convenience, or luxury equipment or features.
vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
vii. Replacement of lost or stolen equipment.
viii. Repairs, adjustments, or replacements necessitated by misuse.
ix. More than one piece of DME serving essentially the same function, except for replacements.
x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
   Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
   i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
   ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
   iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
   iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.

   b. Prosthetic Devices Exclusions
   i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
   ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
   iii. More than one prosthetic device for the same part of the body, except for replacements.
   iv. Spare devices or alternate use devices.
   v. Replacement of lost or stolen prosthetic devices.
   vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
   Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
   i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
   ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless you are covered for these Services under a dental insurance policy or contract.
   iii. Experimental and research braces.
   iv. More than one orthotic device for the same part of the body, except for covered replacements.
   v. Spare devices or alternate use devices.
   vi. Replacement of lost or stolen orthotic devices.
   vii. Repairs, adjustments, or replacements necessitated by misuse.

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

DMES0AB (01-20)

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

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

2. Limitations
   a. IUI coverage is limited to three (3) treatment cycles per lifetime.
   b. Services are covered only for the person who is the Member.

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

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

INFT0AA (01-20)

PREVENTIVE SERVICES RIDER

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

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

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

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

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

14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

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

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

PV0AD (01-20)

RX0BL

PRESCRIPTION DRUG BENEFIT

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

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

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. As long as you are an active Member and the exception request is granted, Health Plan will provide coverage of the non-formulary drug for the duration of the prescription. If the exception request is denied, you, your designee, or your Plan Provider may request an external review of the decision by an independent review organization. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

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

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and that are not listed as generic in the then-current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Physician and obtained at Plan Pharmacies; or
   b. Physician to whom a Member has been referred by a Plan Physician and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the

preferred generic equivalent drug prescribed by the Plan Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, you pay only the brand-name Copayment or Coinsurance.

b. Insulin.

c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.

d. Compounded medications. **Note:** In all Service Areas, if you use a Kaiser Permanente pharmacy, compounded medications must be picked up or mailed from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764- 4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance. In the ***Southern*** and ***Northern Colorado*** Service Areas, you may fill or refill compounded medications at a network pharmacy.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary, for the treatment of substance use disorder.
   b. With the exception of substance use disorder drugs, we may apply Step Therapy to certain drugs. You or your Plan Provider may request an exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Individual drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for Prescription Drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-20)

NOTES

NOTES

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

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COUNTY OF ADAMS

Important plan information

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KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2020

LARGE GROUP

GROUP AGREEMENT

GROUP AGREEMENT

INTRODUCTION

This Group Agreement (*"Agreement"*), including the Rate Sheet(s), the Evidence of Coverage *("EOC")* brochure(s) and the Group Application form, all of which are incorporated into this *Agreement* by reference, and any amendments to any of them, constitute the entire contract between the group named on the Rate Sheet ("Group") and Kaiser Foundation Health Plan of Colorado ("Health Plan"). In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *Evidence of Coverage* document for terms you should know. Pursuant to this *Agreement,* Health Plan will provide covered Services to Members in accordance with the *Evidence of Coverage.*

TERM OF *AGREEMENT* and RENEWAL

Term of Agreement

This *Agreement* is effective for the term shown on the Rate Sheet, unless terminated as set forth in the "Termination of Agreement" section.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew this *Agreement* either by sending Group a new Group Agreement to become effective immediately after termination of this *Agreement*, or by extending the term of this *Agreement* pursuant to "Amendments Effective on an Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended Agreement will include a new term of Agreement and other changes. If Group does not renew this *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination Due to Non-Acceptance of Amendments" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on an Anniversary Date

Upon 60 days' prior written notice to Group with respect to benefit or contract changes, or upon 30 days' prior written notice to Group with respect to rate changes, or as otherwise agreed to by Health Plan and Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on any year's Anniversary Date (the Anniversary Date is shown on the Rate Sheet)..

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary government approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary government approvals. Any such government-approved provisions go into effect on the Anniversary Date that next followed Health Plan's original notice to Group of the provisions for which it had sought government approval (unless the government requires a later effective date).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then beginning on the effective date of that tax or charge, Health Plan may increase

Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in the Health Plan.

Amendment Due to Medicare Changes

Health Plan contracts on a calendar-year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this Agreement to change any Senior Advantage EOCs and Premiums effective January 1, 2020 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits including Member Cost Sharing and the Medicare Part D initial and catastrophic coverage levels. Health Plan will give Group written notice of any such amendment.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to (a) address any law or regulatory requirement, which may include increasing Premiums to reflect an increase in costs to Health Plan or Plan Providers, or (b) reduce or expand the Health Plan Service Area, or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

Group Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of non-acceptance at least 30 days before the effective date of the amendment to the benefits or contract language, or at least 15 days before the effective date of the amendment to rates, in which case this *Agreement* will terminate pursuant to "Termination Due to Non-Acceptance of Amendments" in the "Termination of *Agreement*" section.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on 11:59 p.m. on the termination date, except as expressly provided in the *Evidence of Coverage.*

Health Plan will give Group written notice if this *Agreement* terminates. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 30 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary

date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 60 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

Termination Due to Non-Acceptance of Amendments

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

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

Termination for Nonpayment

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

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

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

Termination for Fraud or for Intentionally Furnishing Incorrect or Incomplete Information

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

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

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's contribution or participation requirements, (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

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

Termination for Movement Outside the Service Area

Health Plan may terminate this *Agreement* upon 30 days' prior written notice to Group if no eligible person lives, resides, or works in Health Plan's Service Area as described in the *Evidence of Coverage.*

Termination for Discontinuance of a Product or all Products within a Market

Health Plan may terminate a particular product or all products offered in the group market as permitted by law. If Health Plan discontinues offering a particular product in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days' prior written notice to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days' written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct evidence of coverage.

Premiums

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

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

Premium Rebates

If state or federal law requires Health Plan to rebate Premiums from this or any earlier contract year and Health Plan rebates Premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

New Members

Premiums are payable for the entire month for new Members unless otherwise agreed to by Health Plan.

Membership Termination

Pursuant to C.R.S. 10-16-103.5, Premiums are payable for each Member:

- Through the date that Health Plan receives written notice from Group that a Member is no longer eligible or covered;
- Through the date that Health Plan receives written notice from Group that it no longer intends to maintain coverage for its Members through Health Plan; or
- Through the date that the Member covered under the policy is no longer eligible or covered if the policyholder notifies the Health Plan within ten (10) business days after the date that the Member is no longer eligible or covered because the Member left employment without notice to the Group or the Member is an employee whose employment was terminated for gross misconduct.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan 30 days' prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or want Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if health Plan receives a termination notice on March 5, for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination

If Health Plan receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accordance with CMS requirements.

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

This "Subscriber Contributions for Medicare Part C Coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute

toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category
  - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C Premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium.

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section, applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D coverage. Group's Senior Advantage Premiums include the Medicare Part D premium. Group may determine how much it will require Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family Unit, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Part D Low Income Subsidy (a subsidy described in 42 C.F.R. Section 423 Subpart P, which is offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduces the Medicare beneficiaries' Medicare Part D premiums or Medicare Part D cost-sharing amounts)
  - Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class.
- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member who exceeds the Premiums for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premiums.
- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for

the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accordance with CMS guidance.

- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount.

Late Enrollment Penalty

If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of that penalty.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan consents in writing. In addition, Group must:

- Contribute to all health care plans available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan. In no case will Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.
- Ensure that:
  - All eligible employees enrolled in Health Plan work at least 20 hours per week.
  - All eligible employees enrolled in Health Plan are covered by Workers' Compensation, unless not required by law to be covered.
  - No less than the percentage of eligible employees, as set forth in the Underwriting Assumptions and Requirements document, are covered by one of the company-sponsored health plans.
  - All Health Plan Subscribers live inside Health Plan's Service Area.
  - The number of active, eligible employee Subscribers enrolled under this Agreement does not fall below 10 and the ratio between the number of Subscribers and the total number of people who are eligible to enroll as Subscribers will not drop by 20 percent or more. For the purpose of computing this percentage requirement, Group may include subscribers and those eligible to enroll as subscribers under all other agreements between Group and Health Plan and all other Kaiser Foundation Health Plans and Group Health Cooperative.
  - There is a bona fide employer/employee relationship to those offered our plan, except eligible Taft-Hartley trusts and partnerships.
- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group.
- Meet all applicable legal and contractual requirements, such as:
  - Group must adhere to all requirements set forth in the applicable *Evidence of Coverage*.

- Group must determine its Member eligibility requirements and obtain Health Plan's prior written approval of any Group eligibility or participation or contribution requirements that are not stated in the applicable *Evidence of Coverage*.
- Group must use Member enrollment application forms that are provided or approved by Health Plan.
- Comply with Centers for Medicare & Medicaid Services (CMS) requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage (KPSA).

- Meet all Health Plan requirements set forth in the "Underwriting Assumptions and Requirements" document.
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group.
- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

Self-Verification of Member Eligibility

Group agrees to assume responsibility for self-verifying the eligibility of its enrolled Members. Such self-verification includes obtaining and verifying the accuracy of any and all supporting documentation received from Groups employees and eligible Dependents. In addition, Group will provide eligibility data to Health Plan that includes coverage effective dates for Group's employees and eligible Dependents to prove that eligibility complies with all applicable federal and state laws and regulations. Upon request, Group will make all verification data and documentation available to Health Plan. Health Plan reserves the right to inspect the verification data and documentation for any reason, at any time during the term of the *Agreement* and up to five (5) years thereafter.

Group further agrees to provide Health Plan with timely notification of enrollment and cancellation of enrolled Dependents, as specified in the "Eligibility and Enrollment" and "Termination of Membership" sections of the *Evidence of Coverage*.

MISCELLANEOUS PROVISIONS

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing and returning the signature page of this document to Health Plan. If Group does not return the executed signature page to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

Note: Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Assignment

Health Plan may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs
If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Commissions
Group's broker may be paid commissions or other incentives by Health Plan.

Delegation of Claims Review Authority
Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has authority to review claims in accordance with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Health Plan is a "named claims fiduciary" with respect to review of claims under this *Agreement*.

Governing Law
Except as preempted by federal law, this *Agreement* will be governed in accordance with the laws of the State of Colorado. Any provision required to be in this *Agreement* by state or federal law shall bind Group and Health Plan whether or not set forth herein.

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

Member Information
Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information.

Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Health Plan will provide SBCs to Members who make a request to Health Plan.

No Waiver

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be delivered in writing to the address listed below, except that

- Health Plan and Group may each change its notice address by giving written notice to the other
- Health Plan may send notices and all other documents to Group's broker instead of sending them directly to Group if Health Plan has a Broker of Record statement from Group
- Health Plan may send notices and all other documents to Group's consultant instead of sending them directly to Group if Group has given Health Plan written notice that Group is represented by a consultant

Notices are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group:

To the most current address on record with Health Plan.

Notices from Group to Health Plan:

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014-1622

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accordance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

Social Security and Tax Identification Numbers

Within 30-60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Group Agreement, along with the following:

- The Member's Social Security number
- The tax identification number of the employer of the Subscriber in the Member's Family Unit

- Any other information that Health Plan is required by law to collect

Time Limit on Reporting Membership Changes
Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accordance with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership **additions** is the calendar month when Health Plan receives Group's notification of the change plus the previous two months, unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Termination
Group must give Health Plan 30 days prior written notice of Senior Advantage Medicare Plus involuntary membership terminations. An involuntary membership termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage Medicare Plus membership termination notice unless Group specifies a later termination date. For example, if Health Plan receives a termination notice on March 5 for a Senior Advantage Medicare Plus Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination
If Health Plan receives a disenrollment notice from CMS or membership termination request from the Member, the membership termination date will be in accordance with CMS requirements.

The administration of COBRA and State Continuation of Coverage participants will be in accordance with applicable Federal and State laws.

The parties have caused this *Agreement* to be executed by their duly authorized officers.

EXECUTED IN DENVER, COLORADO TO TAKE EFFECT AS OF: 1/1/2020

GROUP: COUNTY OF ADAMS 385

BY: _____
Authorized Group Officer Signature

_____
Please Print Your Name and Title

_____
Date Signed

KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NONPROFIT CORPORATION

BY:
Authorized Representative Signature

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

12/12/2019
Date Signed

APPROVED AS TO FORM
COUNTY ATTORNEY

Evidence of Coverage

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

This booklet gives you the details about your Medicare health care and prescription drug coverage during your group's 2020 contract year. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of Colorado (Health Plan). When this Evidence of Coverage says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

This document is available for free in Spanish. Please contact our Member Services number at **1-800-476-2167** for additional information. (TTY users should call **711.**) Hours are 8 a.m. to 8 p.m., 7 days a week.

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **1-800-476-2167**. (Los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a. m. a 8 p. m., siete días a la semana.

This document is available in Braille, large print, or CD if you need it by calling Member Services (phone numbers are printed on the back cover of this booklet).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021, and at other times in accordance with your group's agreement with us. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

EG20001DB MC/12/2019

KPSA-GROUP-PART D DEN(01-20)

KAISER PERMANENTE®

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

COUNTY OF ADAMS RETIREES
385 - 002

Services that are covered for you	What you must pay when you get these covered services
Annual Deductible	No Medical Deductible
Annual out-of-pocket maximum	$2,500/Individual per year
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Alternative therapies *	
Acupuncture	Not Covered
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. • You may need to file a claim for reimbursement unless the provider agrees to bill us (see Chapter 7). • †Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$195 Copayment per trip

Services that are covered for you	What you must pay when you get these covered services
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. This exam is covered once every 12 months.	There is no coinsurance, copayment, or deductible for this preventive care. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Bone-mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

Services that are covered for you	What you must pay when you get these covered services
Cardiac rehabilitation services† Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	
Individual therapy visits.	$15 Copayment each visit or $25 Copayment each visit Copayment dependent upon provider type
Group therapy visits.	Your primary care office visit copayment or $10, whichever is less.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for this cardiovascular disease testing that is covered once every five years. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

Services that are covered for you	What you must pay when you get these covered services
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation. These Medicare-covered services are provided by a participating chiropractor. Please refer to your **Provider Directory** for participating chiropractors providing the Medicare-covered services.	Your primary care office visit copayment or $20 whichever is less. Referral required.
If purchased by your group, supplemental chiropractic services.	$15 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
Laboratory Services or X-rays required for Chiropractic care	See Outpatient diagnostic tests and therapeutic services and supplies
Colorectal cancer screening • For people 50 and older, the following are covered: ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • One of the following every 12 months: ♦ Guaiac-based fecal occult blood test (gFOBT). ♦ Fecal immunochemical test (FIT). • DNA-based colorectal screening every 3 years. • For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. • For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Dental services (from designated providers)*	Please see the Additional Provisions in the back of this booklet to see if your group has purchased coverage for dental services.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

Services that are covered for you	What you must pay when you get these covered services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Diabetes self-management, training and diabetic services and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	No charge
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	20% Coinsurance
• Diabetes self-management training is covered under certain conditions. **Note:** You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare.†	$15 Copayment each visit or $25 Copayment each visit copayment dependent upon provider
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they	20% Coinsurance See Additional Provisions 20% Coinsurance

Services that are covered for you	What you must pay when you get these covered services
can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**.	
Emergency care	
Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **You have worldwide emergency care coverage.**	$65 Copayment each visit Includes X-ray special procedures. This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these covered services
Fitness benefit* A health and fitness benefit is provided through SilverSneakers® Fitness Program that includes the following: • A basic fitness membership with access to all participating fitness locations and their basic amenities. • SilverSneakers® group fitness classes, taught by certified instructors that focus on cardiovascular health, muscle strengthening, flexibility, agility, balance, and coordination. • Health education events and social activities focused on overall well-being. • Access to **www.silversneakers.com/member**, a secure online community for members only, with wellness advice and fitness support information. • You can enroll in SilverSneakers® Steps, a self-directed fitness program for members that includes one home kit to help you get fit at home or on the go. The following are not covered: programs, services, and facilities that carry additional charges, such as racquetball, tennis, and some court sports, massage therapy, lessons related to recreational sports, tournaments, and similar fee-based activities. For more information about SilverSneakers® and the list of participating fitness locations in your area, call toll-free **1-888-423-4632** (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m. (EST) or visit **www.silversneakers.com**. Also, you can simply go to a participating fitness location and show your Senior Advantage membership card to enroll in the program. SilverSneakers is a registered trademark of Tivity Health, Inc.	No charge
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches, certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Contact Member Services for more details. You can also view information online at **kp.org**.	No charge
Hearing services	
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment	$15 Copayment each visit

Services that are covered for you	What you must pay when you get these covered services
are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	
Hearing aids.	Not Covered
Fitting & Recheck visits	$15 Copayment each visit
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam every 12 months. For women who are pregnant, we cover up to three screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care† Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include but are not limited to: • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	No charge Note: There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Home infusion therapy† We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary (or you have a formulary exception). • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	No charge

Services that are covered for you	What you must pay when you get these covered services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. ***For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • *If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). **For services that are covered by our plan but are not covered by Medicare Part A or B:** We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4, "What if you're in Medicare-certified hospice." **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, **not** our plan.

Services that are covered for you	What you must pay when you get these covered services
Hospice care for members without Part A For members without Part A, the hospice benefit described earlier in this section does not apply to members who are not enrolled in Medicare Part A. Our plan, rather than Original Medicare, covers hospice care for members who are not enrolled in Medicare Part A. Members must receive hospice services from network providers.	No charge
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care†	
Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification).	$250 Copayment per admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2019 and are not discharged until sometime in 2020, the 2019 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

Services that are covered for you	What you must pay when you get these covered services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. **Note:** Travel and lodging expenses must be authorized by Medical Group when a network physician refers you to an out-of-network provider outside our service area for transplant services. We will pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. For information specific to your situation, please contact your assigned Transplant Coordinator or call the Transplant Administrative Offices at **1-877-895-2705** (TTY users may call **711**). • Blood - including storage and administration. • Physician services **Note:** To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an "inpatient," or an "outpatient," you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, *"Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!*" This fact sheet is available on the Web at **https://www.medicare.gov/Pubs/pdf/11435.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient substance abuse treatment†	
• Substance abuse inpatient medical detoxification.	$250 Copayment per admission
• Substance abuse inpatient rehabilitation.	$250 Copayment per inpatient admission
Inpatient mental health care†	
Covered services include mental health care services that require a hospital stay.	$250 Copayment per admission

Services that are covered for you	What you must pay when you get these covered services
• We cover up to 190-days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay†	
If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the the hospital or SNF. Covered services include but are not limited to: Covered services include: • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings. • Splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition). • Physical therapy, speech therapy, and occupational therapy.	Medicare Part B medical services, will be covered as described under their respective benefit headings: • Physician services, including doctor office visits. • Outpatient diagnostic tests and therapeutic services and supplies. • Prosthetic devices and related supplies. • Outpatient rehabilitation services. • Physical therapy, speech therapy, and occupational therapy.

Services that are covered for you	What you must pay when you get these covered services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew his or her order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members-eligible for Medicare-covered medical nutrition therapy services. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these covered services
Medicare Part B prescription drugs† These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually are not self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Antigens. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	No Charge
• Clotting factors you give yourself by injection if you have hemophilia. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	You pay the same cost-sharing for these Part B drugs when dispensed through a network pharmacy as reflected in the prescription drug section below.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

Services that are covered for you	What you must pay when you get these covered services
Opioid treatment program services† Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include:	
• FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable.	**Office administered Medicare Part B treatment medications:** See "Medicare Part B prescription drugs" **Dispensing and administration:** You will pay one Outpatient substance abuse services copayment per month
• Substance use counseling • Individual and group therapy. • Toxicology testing.	See Specialty care visits under "Physician/practitioner services, including doctor's office visits"
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • Laboratory tests. • †Blood -including storage and administration.	No charge
• †Surgical supplies, such as dressings. • †Splints, casts, and other devices used to reduce fractures and dislocations.	20% Coinsurance
• †X-rays.	No Charge, per x-ray
• †Other outpatient diagnostic tests — special procedures such as MRI, CT, PET scans and nuclear medicine.	$100 Copayment per procedure
• †Radiation (radium and isotope) therapy, including technician, materials and supplies	$25 Copayment
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/Pubs/pdf/11435.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	What you must pay when you get these covered services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	No charge Note: There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or outpatient surgery.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services† Outpatient hospital services at designated facilities, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room.	$200 Copayment each visit
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	What you must pay when you get these covered services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	
Outpatient individual therapy (includes visits to monitor outpatient drug therapy). "Partial hospitalization" is a structured program of active psychiatric treatment, provided in a hospital outpatient setting or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy.	50% of individual therapy Copayment
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$15 Copayment each visit
Outpatient substance abuse services We provide treatment and counseling services to diagnose and treat substance abuse (including individual and group therapy visits).	
Outpatient individual therapy	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy	50% of individual therapy Copayment
Outpatient surgery†, including services provided at hospital outpatient facilities and ambulatory surgical centers	
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$200 Copayment each surgery

Services that are covered for you	What you must pay when you get these covered services
Prescription drugs	
Deductible for Outpatient prescription drugs	Not Applicable
Initial Coverage Stage • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Total Drug Costs	$5 Generic/$15 Non-Preferred Generic/$40 Brand name/$60 Non-Preferred Brand name/$60 Specialty/No Charge injectable Part D vaccines Up to $4,020
Coverage Gap Stage • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Out-of-Pocket Costs	$5 Generic/$15 Non-Preferred Generic/$40 Brand name/$60 Non-Preferred Brand name/$60 Specialty/No Charge injectable Part D vaccines Up to $6,350
• Prescribed supplies and accessories.	No Charge
Infertility drugs.	Not Covered
Sexual dysfunction drugs.	Not Covered
	Supply Limit
Day supply limit.	30 days
Mail-order supply limit.	90 days @ 2 Copayments
Physician/practitioner services, including doctor's office visits	
"Providers" include, but are not limited to, physicians, physician assistants and nurse practitioners. Covered services include: Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location.	
Primary care visits	$15 Copayment each visit
Specialty care visits (doctor or nurse visit).	$25 Copayment each visit
Second opinion by another network provider prior to surgery.	Your primary care office visit copayment or specialty care office visit copayment, as applicable.
Outpatient surgery services†	$200 Copayment each surgery
Consultations with clinical pharmacists	$15 Copayment each visit

Services that are covered for you	What you must pay when you get these covered services
• Certain telehealth services, including for: primary and specialty care, which includes cardiac and pulmonary rehabilitation, mental health care, substance abuse treatment, kidney disease, diabetes self-management, preparation for a hospital stay, and follow up visits after a hospital stay or Emergency Department visit. Services will only be provided via telehealth when deemed clinically appropriate by the network provider rendering the service. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. We offer the following means of telehealth: ♦ Interactive video visits for professional services when care can be provided in this format as determined by a network provider. ♦ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider. • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke. • Brief virtual (for example, via telephone or video chat) 5- to 10-minute check-ins with your doctor, if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Remote evaluation of prerecorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours (except weekends and holidays)—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient.	No Charge
Non-routine dental care† (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw	See specialty care office visit and Outpatient surgery cost-sharing above.

Services that are covered for you	What you must pay when you get these covered services
for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	
Chemotherapy visits.	Your specialty care office visit copayment plus your copayment or coinsurance for office-administered drugs.
Allergy injections.	$15 Copayment each visit Copayment may apply for allergy serum
Allergy evaluation and testing. • Primary care visits • Specialty care visits	 $15 Copayment each visit $25 Copayment each visit
Group visits—Cooperative Health Care Clinic (CHCC), Drop in Group Medical Appointment (DIGMA) and group mental health and substance abuse treatments.	Your primary care office visit copayment or $10 copayment each visit, whichever is less.
Podiatry services	
Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	See primary care office visit, specialty care office visit, and †Outpatient surgery cost-sharing above.
Prostate cancer screening exams For men age 50 and older, covered services include the following – once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no coinsurance, copayment or deductible for an annual digital rectal exam or PSA test. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive care you receive during or subsequent to the visit.
Prosthetic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision care" later in this section for more detail.	
Prosthetics	20% Coinsurance
Internally implanted prosthetic devices.	(See Hospital Inpatient Care and Outpatient Care for applicable cost-sharing)
Enteral and parenteral nutrition therapy covered under Medicare.	No Charge

Services that are covered for you	What you must pay when you get these covered services
Prosthetic arm or leg.	20% Coinsurance
Orthotic devices and related supplies.	20% Coinsurance
Oxygen	20% Coinsurance
Pulmonary rehabilitation services.† Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$5 Copayment each visit
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. • Eligible members are people aged 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. • For LDCT lung cancer screenings after the initial LDCT screening, the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these covered services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurances, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Services to treat kidney disease and conditions	
Covered services include: Kidney disease education services to teach kidney care and help members make informed decisions about their care.	$15 Copayment each visit or $25 Copayment each visit copayment dependent upon provider
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs".	No Charge

Services that are covered for you	What you must pay when you get these covered services
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body such as blood clotting factors.) • Blood – including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). A SNF where your spouse is living at the time you leave the hospital.	No Charge Limited to 100 days per benefit period A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row. **Note:** If a benefit period begins in 2019 for you and does not end until sometime in 2020, the 2019 cost-sharing will continue until the benefit period ends.

Services that are covered for you	What you must pay when you get these covered services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	$30 Copayment each visit
Urgently needed services	
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or	$40 Copayment each visit

Services that are covered for you	What you must pay when you get these covered services
by out-of-network providers when network providers are temporarily unavailable or inaccessible. Urgently needed services received in a network urgent care department (or facility) and covered out-of-network urgent care when you are temporarily outside our service area. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel, if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area.	
Vision care	
Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people with diabetes, screening for diabetic retinopathy is covered once per year. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan covers the following exams: Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses.	
Eye exams performed by an optometrist	$15 Copayment each visit
Eye exams performed by an ophthalmologist.	$25 Copayment each visit
For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older: Glaucoma screening once per year.	No charge, unless member receives the screening in conjunction with other services, such as a routine eye exam, then member will be charged the applicable copayment.

Services that are covered for you	What you must pay when you get these covered services
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Following Medicare-covered cataract surgery, the member may use their eyewear benefit (if purchased by your group) as described below to pay for upgrades to the Medicare covered eye wear benefit. The Medicare eyewear benefit following cataract surgery is covered per Medicare guidelines.	No charge, unless the cost exceeds the allowed Medicare fee schedule.
If purchased by your group, lenses, frames, medically necessary contact lenses, or cosmetic contact lenses every two years, purchased at a network optical facility. Any part of the eyewear benefit that is not exhausted at the first point of sale may not be used at a later date. This means that any benefit dollars remaining after the first point of sale are forfeited and cannot be applied to copayments for eye exams or contact lens professional fitting fees. • Eyeglasses and contact lenses must be prescribed by an optometrist or ophthalmologist and purchased at a network optical facility. • See exclusions for eye surgery to correct refractive defects and for cosmetic contact lenses that are not medically necessary later in this section.	$100 Credit every 24 months See Additional Provisions *
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

2020 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

CHAPTER 1. Getting started as a member

SECTION 1. Introduction

Section 1.1 You are enrolled in Senior Advantage, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Kaiser Permanente Senior Advantage.

There are different types of Medicare health plans. Senior Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). approved by Medicare and run by a private company.

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

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of our plan.

If you are not certain which plan you are enrolled, please call Member Services or your group's benefit administrator.

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

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

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

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

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment form, our **Kaiser Permanente 2020 Comprehensive Formulary**, and any notices you receive from us about changes to your

coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

If your group renews on January 1st, the **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2020, and December 31, 2020, unless amended. If your group's agreement renews at a later date in 2020, the term of this **Evidence of Coverage** is during that contract period, unless amended. Your group can tell you the term of this **Evidence of Coverage** and whether this **Evidence of Coverage** is still in effect and give you a current one if this **Evidence of Coverage** has been amended.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020. In addition, your group can make changes to the plans and benefits it offers at any time.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (or Medicare Part B) (Section 2.2 below tells you about Medicare Part A and Medicare Part B).
- *-and-* you live in our geographic service area (Section 2.3 below describes our service area).
- *-and-* you are a United States citizen or are lawfully present in the United States.
- *-and-* you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is our plan service area for Senior Advantage

Although Medicare is a federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Colorado: **Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin and Jefferson.**

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a special enrollment period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important to notify your group's benefits administrator and that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

Section 2.5 Group eligibility requirements

You must meet your group's eligibility requirements that we have approved. Your group is required to inform subscribers of its eligibility requirements, such as dependent eligibility requirements (for example, your spouse).

Please note that your group might not allow enrollment to some persons who meet the requirements described under "Additional eligibility requirements" below.

Additional eligibility requirements

Subscriber. You may be eligible to enroll as a subscriber under this **Evidence of Coverage** if you are entitled to subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

If you are a subscriber under this Evidence of Coverage or a subscriber enrolled in a non-Medicare plan offered by your group, the following persons may be eligible to enroll as your dependents under this Evidence of Coverage if they meet all the other requirements described in this section 2.5:

- Your spouse. (Spouse includes a partner in a valid civil union under state law.)
- Your or your Spouse's children (including adopted children, children placed with you for adoption, and foster children) who are under the dependent limiting age. Check with your group to determine the age limit for dependents.

- Other dependent persons who meet all of the following requirements:
  - they are under the dependent limiting age as determined by your group
  - you or your spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
- Your or your spouse's unmarried children of any age who are medically certified as disabled and dependent upon you or your spouse are eligible to enroll or continue coverage as your dependents if the following requirements are met:
  - they are dependent on you or your spouse; and
  - you give us proof of the dependent's disability and dependency annually if we request it.
- Subscriber's designated beneficiaries as defined by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on medical leave of absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a medically necessary leave of absence remain eligible for coverage until the earlier of (i) one year after the first day of the medically necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under the non-Medicare plan offered by your group. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is medically necessary.

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this Evidence of Coverage, you may be able to enroll them as your dependents under a non-Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If your plan has different eligibility requirements, please see "Additional Provisions."

Section 2.5 When you can enroll and when coverage begins

Your group is required to inform you when you are eligible to enroll and what your effective date of coverage is under this **Evidence of Coverage.** If you are eligible to enroll as described in this section, enrollment is permitted and membership begins at the beginning (12 a.m.) of the effective date of coverage, except that:

- Your group may have additional requirements that we have approved, which allow enrollment in other situations.
- The effective date of your Senior Advantage coverage under this **Evidence of Coverage** must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this section.

If you are a subscriber under this **Evidence of Coverage** and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this **Evidence of Coverage**, you may be able to enroll them as your dependents under a non-

Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a dependent under this **Evidence of Coverage** but the subscriber in your family is enrolled under a non-Medicare plan offered by your group, the subscriber must follow the rules applicable to subscribers who are enrolling dependents in this Section 2.5.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage enrollment form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this **Evidence of Coverage.**

If CMS confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If CMS tell us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New subscribers

When your group informs you that you are eligible to enroll as a subscriber, you may enroll yourself and any eligible dependent by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group within 31 days after you become eligible, or as otherwise specified by your group.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new subscribers and their eligible family dependents is determined by your group, subject to confirmation by CMS.

Employees who are not enrolled when newly eligible must wait until the next open enrollment period to become members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your group and Health Plan or (ii) they enroll under the provisions described in "Special Enrollment Due to Loss of Other Coverage" below.

Adding new dependents to an existing account

To enroll a dependent who first becomes eligible to enroll after you became a subscriber (such as a new spouse, a newborn child, or a newly adopted child), you must submit a Health Plan-approved enrollment form and a Senior Advantage enrollment form to your group within 31 days after the dependent first becomes eligible, or as otherwise specified by your group.

Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your group and Health Plan or (ii) they enroll under the provisions described in "Special Enrollment Due to Loss of Other Coverage" below.

Effective date of Senior Advantage coverage. The effective date of coverage for newly acquired dependents is determined by your group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a subscriber (along with any eligible dependents), and existing subscribers may add eligible dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group during your group's open enrollment period. Your group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by CMS.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless you become eligible as described in this "Special enrollment" section.

Special enrollment events

You may enroll as a subscriber (along with any eligible dependents), and existing subscribers may add eligible dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group within 31 days after the enrolling persons lose other coverage, if:

The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason); and the loss of the other coverage is due to one of the following: For a comprehensive list of qualifying events for special enrollment see your Group's administrator to obtain a copy of your Group's **Evidence of Coverage.**

Open enrollment

You may enroll as a subscriber (along with any eligible dependents), and existing subscribers may add eligible dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group during your group's open enrollment period. Your group will let you know when the open enrollment period begins and ends and the membership effective date, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card—use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

As long as you are a member of our plan, in most cases, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your new Medicare card if you need hospital services. Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Senior Advantage membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Section 3.2 The Provider Directory: Your guide to all providers in our network

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at **kp.org/directory**.

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

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

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You

can view or download the **Provider Directory** at **kp.org/directory**. Both Member Services and our website can give you the most up-to-date information about our network providers.

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

What are "network pharmacies"?

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

Why do you need to know about network pharmacies?

Our network has changed more than usual for 2020. An updated **Pharmacy Directory** is located on our website at **kp.org**. You may also call Member Services for updated provider information or to ask us to mail you a current **Pharmacy Directory.** We strongly suggest that you review our current **Pharmacy Directory** to see if your pharmacy is still in our network. This is important because, with few exceptions, you must get your prescriptions filled at a network pharmacy if you want our plan to cover (help pay for) them.

The **Pharmacy Directory** will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

If you don't have the **Pharmacy Directory**, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at **kp.org/directory**.

Section 3.4 Our plan's list of covered drugs (formulary)

Our plan has a **Kaiser Permanente 2020 Comprehensive Formulary**. We call it the "Drug List" for short. It tells you which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our Drug List. The Drug List also tells you if there are any rules that restrict coverage for your drugs.

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

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

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

The **Part D EOB** tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 ("What you pay for your Part D prescription drugs") gives you more information
about the **Part D EOB** and how it can help you keep track of your drug coverage.

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

SECTION 4. Your monthly premium for our plan

Section 4.1 How much is your plan premium?

Plan premiums

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

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

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

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

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends upon how

long you went without Part D or creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

If you are required to pay a Part D late enrollment penalty, your group will inform you the amount that you will be required to pay your group.

If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2020, this average premium amount is $32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

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

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

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

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

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

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." **Please note:**
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later. Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your **Medicare & You** 2020 handbook or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

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

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

SECTION 6. Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, **you must pay an extra amount directly to the government** for your Medicare Part D coverage.

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

Section 6.2 How much is the extra Part D amount?

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

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

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

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

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

SECTION 7. More information about your monthly premium

Many members are required to pay other Medicare premiums

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

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related

Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from our plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Section 6 of this chapter. You can also visit **https://www.medicare.gov** on the Web or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or you may call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

Your copy of **Medicare & You** 2020 gives you information about Medicare premiums in the section called "2020 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You** 2020 from the Medicare website (**https://www.medicare.gov**) or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 7.1 Paying your plan premium

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

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

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

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

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

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

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 9. We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4, of this booklet.

SECTION 10. How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends upon your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance).
- Liability (including automobile insurance).
- Black lung benefits.
- Workers' compensation.

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2. Important phone numbers and resources

SECTION 1. Kaiser Permanente Senior Advantage contacts
(how to contact us, including how to reach Member Services at our plan)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Senior Advantage Member Services. We will be happy to help you.

Method	Member Services – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**303-214-6489**
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**

How to contact us when you are asking for a coverage decision or making a complaint about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section about making an appeal.) For more information about asking for coverage decisions or making complaints about your medical care, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

Method	Coverage decisions or complaints about medical care – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-866-466-4042**
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
MEDICARE WEBSITE	You can submit a **complaint** about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**.

How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section below about making an appeal.)

For more information about asking for coverage decisions or making complaints about your Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

Method	Coverage decisions or complaints about Part D prescription drugs – contact information
CALL	**1- 800-476-2167** Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.

TTY	**711** Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.
FAX	**1-866-455-1053**
WRITE	Kaiser Foundation Health Plan of Colorado Pharmacy Benefits and Compliance 16601 East Centretech Parkway Aurora, CO 80011
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a **complaint** about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**.

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

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

Method	Appeals for medical care or Part D prescription drugs – contact information
CALL	**1-888-370-9858** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
FAX	**1-866-466-4042**
WEBSITE	**kp.org**
WRITE	Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

Method	Payment requests – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Foundation Health Plan of Colorado Claims Department P.O. Box 373150 Denver, CO 80237-3150
WEBSITE	**kp.org**

SECTION 2. Medicare (how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our plan.

Method	Medicare – contact information
CALL	**1-800-MEDICARE or 1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048**

Method	Medicare – contact information
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**https://www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Colorado, the SHIP is called Colorado State Health Insurance Assistance Program ("Colorado SHIP").

Colorado SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Colorado SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Colorado SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Colorado State Health Insurance Assistance Program – contact information
CALL	**1-888-696-7213**
WRITE	SHIP, Colorado Division of Insurance 1560 Broadway St., Ste. 850 Denver, CO 80202
WEBSITE	**https://www.colorado/gov/pacific/dora/senior-healthcare-medicare**

SECTION 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Colorado, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Colorado's Quality Improvement Organization) – contact information
CALL	**1-888-317-0891** Calls to this number are free. Monday to Friday, 9 a.m. to 5 p.m. Weekends and holidays, 11 a.m. to 3 p.m.
TTY	**1-855-843-4776** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 Attention: Beneficiary Complaints
WEBSITE	https://**www.keproqio.com**

SECTION 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – contact information
CALL	**1-800-772-1213**

Method	Social Security – contact information
	Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**https://www.ssa.gov**

SECTION 6. **Medicaid** (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Health First Colorado (Medicaid).

Method	Health First Colorado (Colorado's Medicaid program) – contact information
CALL	**1-800-221-3943** Calls to this number are free. Monday to Friday, 8 a.m. to 4:30 p.m.
TTY	**711**

Method	Health First Colorado (Colorado's Medicaid program) – contact information
WRITE	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203
WEBSITE	**https://www.healthfirstcolorado.com**

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

Medicare's "Extra Help" Program

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

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

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

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

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

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

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

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

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

Medicare Coverage Gap Discount Program

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

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

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

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

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

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

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

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

What is the AIDS Drug Assistance Program (ADAP)?

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

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

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

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

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

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

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

State Pharmaceutical Assistance Programs

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

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

Method	Bridging the Gap Colorado - contact information
CALL	**303-692-2716** Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Bridging the Gap Colorado C/O Colorado ADAP A3-3800 4300 Cherry Creek Drive South Denver, Colorado 80246-1530
WEBSITE	**https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap**

SECTION 8. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – contact information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.

TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are ***not*** free.
WEBSITE	**https://www.secure.rrb.gov**

SECTION 9. Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this booklet. You may also call **1-800-MEDICARE** (**1-800-633-4227**; TTY: **1-877-486-2048**) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3. Using our plan's coverage for your medical services

SECTION 1. Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. It gives you definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by our plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the Medical Benefits Chart found at the front of this **EOC**.

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart found at the front of this **EOC**.

Section 1.2 Basic rules for getting your medical care covered by our plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

We will generally cover your medical care as long as:

- **The care you receive is included in our plan's Medical Benefits Chart** (found at the front of this **EOC**).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP)** who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).
  - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
  - We cover emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider if we authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.3 in this chapter.
  - We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.

SECTION 2. Use providers in our network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

As a member of our plan, you must choose a network provider to be your primary care provider (PCP). Your PCP is a health care professional who meets state requirements and is trained to give you primary medical care.

Your PCP will provide most of your care and may help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other network providers about your care and how it is going.

There are a few types of covered services you can get on your own without contacting your PCP first (see Section 2.2 in this chapter).

In some cases, your PCP will also need to get prior authorization (prior approval) from us. The services that require prior authorization from us are discussed in Section 2.3 of this chapter.

How do you choose your PCP?

You may choose a primary care provider from any of our available network physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. When you make a selection, it is effective immediately. To learn how to choose a primary care provider, please call our Personal Physician Selection Services at **1-855-208-7221** (TTY **711**), weekdays 7 a.m. to 5:30 p.m. You can also make your selection at **kp.org**.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our network of providers and you would have to find a new PCP. To change your PCP, call our Personal Physician Selection Team at **1-855-208-7221** or **711** (TTY), weekdays 7 a.m. to 5:30 p.m., or make your selection at **kp.org**.

When you call, be sure to tell our Personal Physician Selection Team if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Our Personal Physician Selection Team will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. When you make a new selection, the change is effective immediately.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (for example, when you are temporarily outside of our service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.) Phone numbers for Member Services are printed on the back cover of this booklet.
- Consultation (routine office) visits to specialty-care departments within our plan, with the exception of the anesthesia clinical pain department.
- Second opinions from another network provider.
- Mental health care or substance abuse services, as long as you get them from a network provider.
- Preventive care except barium enemas, as long as you get them from a network provider.

- Chiropractic services as long as you get them from a network provider.
- Routine eye exams and hearing exams, as long as you get them from a network provider.
- Covered routine care from any Colorado Permanente Medical Group (CPMG) physician at any Kaiser Permanente medical office in our Southern Colorado or Northern Colorado service areas. Note: You cannot get routine care from affiliated network providers in the Southern Colorado or Northern Colorado service areas.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first, which are described in Section 2.2 of this chapter.

When your PCP prescribes specialized treatment, he or she will give you a referral to see a network specialist or certain other network providers. However, for some types of specialty care referrals, your PCP may need to get approval in advance from our plan. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

Prior authorization

For the services and items listed below and in Chapter 4, Sections 2.1 and 2.2, your network provider will need to get approval in advance from our plan (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

- For **certain specialty care**, your PCP will recommend to our plan that you be referred to a network specialist. The plan will authorize the services if it is determined that the covered services are medically necessary. Referrals to such specialist will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network physician what services have been authorized. If the specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your PCP. You must have an authorized referral for ongoing treatment from a network specialist except as described in Section 2.2. If you don't have a referral (approval in advance) before you get certain ongoing services, you may have to pay for these services yourself.
- If your network provider decides that you require **covered services not available from network providers**, he or she will recommend to our plan that you be referred to an out-of-

network provider inside or outside our service area. The plan will authorize the services if it is determined that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network provider what services have been authorized. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your network provider.

- If your network physician makes a written referral for **bariatric surgery**, the service will be evaluated for medical necessity by our bariatric surgeon and the Metabolic Surgery and Weight Management Department.
- After we are notified that you need **post-stabilization care** from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.
- Medically necessary **transgender surgery** and associated procedures.
- Care from a **religious nonmedical health care institution** described in Section 6 of this chapter.
- If your specialist makes a written referral for a **transplant**, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are medically necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, the Medical Group will designate a specialist within the group to review and approve your transplant referral.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us at **1-855-208-7221** (TTY **711**), weekdays, 7 a.m. to 5:30 p.m., so we can assist you in finding a new provider and managing your care.

Section 2.4 How to get care from out-of-network providers

Care you receive from an out-of-network provider will not be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- We authorize a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area. Please call Member Services or our away from home travel line at **1-951-268-3900** (24 hours a day, 7 days a week except holidays), TTY **711**, for more information about getting care when visiting another Kaiser Permanente region's service area, including coverage information and facility locations in the District of Columbia and parts of California, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

SECTION 3. How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible**. Call **911** for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency**. We need to follow up on your emergency care. You or someone else should call to tell us about

your emergency care, usually within 48 hours. The number to call is listed on the back of your plan membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere inside or outside the United States. We cover ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart found at the front of this **EOC**.

You may get covered emergency medical care (including ambulance) when you need it anywhere in the world. However; you may have to pay for the services and file a claim for reimbursement (see Chapter 7 for more information).

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. We will cover your follow-up post-stabilization care in accord with Medicare guidelines. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, we will cover your care as long as you reasonably thought your health was in serious danger.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- Or the additional care you get is considered "urgently needed services" and you follow the rules for getting these urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or

inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in our service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, seven days a week, or make an appointment, please call **1-800-218-1059 (**TTY **711).**

What if you are outside our service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, we will cover urgently needed services that you get from any provider. Our plan covers worldwide urgent care services outside the United States under the following circumstances:

- You are temporarily outside of our service area.
- The services were necessary to treat an unforeseen illness or injury to prevent serious deterioration of your health.
- It was not reasonable to delay treatment until you returned to our service area.
- The services would have been covered had you received them from a network provider.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from us.

Please visit the following website—**kp.org**—for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, we will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5, for more information.

SECTION 4. What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs," for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

We cover all medical services that are medically necessary, listed in the Medical Benefits Chart (this chart is found at the front of this **EOC**), and obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted will not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs:

- We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
  - Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

- In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare will not pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (**https://www.medicare.gov**). You can also call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1 What is a religious nonmedical health care institution?

A religious nonmedical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious nonmedical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (nonmedical health care services). Medicare will only pay for nonmedical health care services provided by religious nonmedical health care institutions.

Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?

To get care from a religious nonmedical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious nonmedical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in the Medical Benefits Chart found at the front of the **EOC**, Chapters 4 and 12.

SECTION 7. Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in

order to own the item. There are no exceptions to this case when you return to Original Medicare.

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CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1. Understanding your out-of-pocket costs for covered services

This chapter and the Medical Benefits Chart found at the front of this **EOC** focuses on your covered services and what you pay for your medical benefits. The Medical Benefits Chart lists your covered services and some limitations and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapters 3, 11, and 12 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your copayments.)
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart located found at the front of this **EOC** tells you more about your coinsurance.)
- The "**deductible**" is the amount you must pay for medical services before our plan begins to pay its share for your covered medical services. (**Note**: Not all plans have a deductible.) Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance). The deductible does not apply to some services. (The Medical Benefits Chart found at the front of this **EOC** tells you if your plan has a deductible, the deductible amount, and which services are subject to the deductible.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare

Part A and Part B (see the Medical Benefits Chart located at the front of this **EOC**). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2020 is stated in the Medical Benefits Chart found at the front of this **EOC**. The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*****) in the Medical Benefits Chart found at the front of this **EOC**.

If you reach the maximum out-of-pocket amount stated in the Medical Benefits Chart found at the front of this **EOC**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that, after you meet any deductibles (if applicable to your plan), you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)

- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2. Use the Medical Benefits Chart at the front of this EOC to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of our plan

The Medical Benefits Chart found at the front of this **EOC** lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart found at the front of this **EOC** with a footnote (†). In addition, see Section 2.2 in this chapter and Chapter 3, Section 2.3, for more information about prior authorization, including other services that require prior authorization that are not listed in the Medical Benefits Chart found at the front of this **EOC.**

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2020** handbook. View it online at **https://www.medicare.gov** or ask for a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, cost-sharing will apply for the care received for the existing medical condition.
- Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the Medical Benefits Chart found at the front of this **EOC**.

SECTION 3. What services are not covered by our plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that we don't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception is we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3, in this booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart at the front of this **EOC** or in the chart below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		√ This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Experimental medical and surgical procedures, equipment and medications • Experimental procedures and items are those items		√ May be covered by Original Medicare under a Medicare-approved clinical research study.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community		(See Chapter 3, Section 5 for more information about clinical research studies.)
Private room in a hospital		√ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	√	
Full-time nursing care in your home	√	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care • Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Fees charged by your immediate relatives or members of your household	√	
Cosmetic surgery or procedures		√

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings, or dentures		√ Not covered unless your group has purchased coverage. Refer to the Medical Benefits Chart at the front of this **EOC**.
Nonroutine dental care		√ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		√ Manual manipulation of the spine to correct a subluxation is covered. In addition, this exclusion does not apply if your employer purchased coverage for additional chiropractic care. Refer to the Medical Benefits Chart at the front of this **EOC**.
Routine foot care		√ Some limited coverage provided according to Medicare guidelines, for example, if you have diabetes.
Home-delivered meals	√	
Orthopedic shoes		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		√ Orthopedic or therapeutic footwear for people with diabetic foot disease.
Hearing aids		√ This exclusion does not apply if your group has purchased hearing aid coverage. Refer to the Medical Benefits Chart in the front of this **EOC**. **Note**: For all members, this hearing aid exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.
Industrial frames	√	
Lenses and sunglasses without refractive value		√ This exclusion does not apply to any of the following items: • A clear balance lens if only one eye needs correction. • Tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa.
Replacement of lost, broken, or damaged lenses or frames	√	
Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling	√	
Eyewear items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Radial keratotomy, LASIK surgery, and other low vision aids	√	
Reversal of sterilization procedures and non-prescription contraceptive supplies.	√	
Acupuncture		√ This exclusion does not apply if your employer has purchased coverage for acupuncture. Refer to the Medical Benefits Chart at the front of the **EOC**.
Naturopath services (uses natural or alternative treatments)	√	
Private duty nursing	√	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		√ Covered if medically necessary and covered under Original Medicare.
Services provided to veterans in Veterans Affairs (VA) facilities		√ When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or		√ We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
reshape normal structures of the body in order to improve appearance		defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Surgery that, in the judgment of a network physician specializing in reconstructive surgery, offers only a minimal improvement in appearance. Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance	√	
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)		√ You may request and we may provide insertion of a presbyopia-correcting IOL or astigmatism-correcting IOL following cataract surgery in lieu of a conventional IOL. However, you must pay the difference between Plan Charges for a nonconventional IOL and associated services and Plan Charges for insertion of a conventional IOL following cataract surgery.
Directed blood donations	√	
Massage therapy		√ Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Transportation by air, car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance),	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
even if it is the only way to travel to a network provider		
Licensed ambulance services without transport		√ Covered if the ambulance transports you or if covered by Medicare.
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		√ Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Services related to noncovered services or items		√ When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA		√ This exclusion applies to services provided anywhere, even outside the U.S. It doesn't apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.

CHAPTER 5. Using our plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The Medical Benefits Chart found at the front of this **EOC** and the next chapter tell you what you pay for Part D drugs (Chapter 6, "What you pay for your Part D prescription drugs").

In addition to your coverage for Part D drugs, we also cover some drugs under our plan's medical benefits. Through our coverage of Medicare Part A benefits, we generally cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through our coverage of Medicare Part B benefits, we cover drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The Medical Benefits Chart found at the front of this **EOC** tells you about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. We only cover Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions, and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 in this chapter, "What if you're in Medicare-certified hospice." For information on hospice coverage, see the hospice section of the Medical Benefits Chart at the front of this **EOC**.

If your group has purchased enhanced Part D prescription drug coverage, we cover some drugs that are not covered by Medicare Part B and Part D in accord with our formulary for non-Part D

drugs. The Medical Benefits Chart at the front of this **EOC** tells you about your benefits and costs for these drugs.

The following sections discuss coverage of your drugs under our plan's Part D benefit rules. Section 9 in this chapter, "Part D drug coverage in special situations," includes more information about your Part D coverage and Original Medicare.

Section 1.2 Basic rules for our plan's Part D drug coverage

Our plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, "Fill your prescriptions at a network pharmacy or through our mail-order service.")
- Your drug must be on our **Kaiser Permanente 2020 Comprehensive Formulary** (we call it the "Drug List" for short). (See Section 3, "Your drugs need to be on our Drug List.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2. Fill your prescription at a network pharmacy or through our mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at our network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on our plan's Drug List.

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (**kp.org/directory**), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing rather than a network pharmacy that offers standard cost-sharing. The **Pharmacy Directory** will tell you which of the network pharmacies offer preferred cost-sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us. If you switch from one network pharmacy. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in our network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost-sharing, you may switch to a different pharmacy. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at **kp.org/directory**.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.
  Note: This scenario should happen rarely.

To locate a specialized pharmacy, look in your **Pharmacy Directory** or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using our mail-order services

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, the drugs provided through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List.

Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply.

To get information about filling your prescriptions by mail, call Member Services.
You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call our mail-order service at **1-866-523-6059 (TTY 711)**, Monday through Friday, 8 a.m. to 6 p.m.
- Call the highlighted number listed on your prescription label and follow the prompts. Be sure to select the mail delivery option when prompted.
- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular mail-order service). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed or see our *Drug List* for information about the drugs that can be mailed.

Usually a mail-order pharmacy order will get to you in no more than 5 days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local preferred network retail pharmacy listed in your **Pharmacy Directory** or at **kp.org/directory**. Please be aware that you may pay more if you get a 90-day supply from a network retail pharmacy instead of from our preferred mail-order pharmacy.

Refills on mail-order prescriptions. For refills, please contact your pharmacy at least 5 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. When you place your order, please provide your current contact information in case we need to reach you.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. Our plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition. You may order this supply through mail order (see Section 2.3 in this chapter) or you may go to a retail pharmacy.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use our plan's network mail-order services. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List. Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. **Note:** Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).

- If you are not able to get your prescriptions from a network pharmacy during a disaster.

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. Phone numbers for Member Services are printed on the back cover of this booklet. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, explains how to ask us to pay you back.)

SECTION 3. Your drugs need to be on our "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

Our plan has a **Kaiser Permanente 2020 Comprehensive Formulary**. In this **Evidence of Coverage**, we call it the "Drug List" for short.

The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Or supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

Our Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

What is not on our Drug List?

Our plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are six "cost-sharing" tiers" for drugs on our *Drug List*

Every drug on our plan's Drug List is in one of six cost-sharing tiers. Depending upon the plan your group has selected, cost-sharing may vary from one tier to the next. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs.
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs (this tier includes some generic drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up on our Drug List. The amount you pay for drugs in each cost-sharing tier is shown in the Medical Benefits Chart found at the front of this **EOC**.

Section 3.3 How can you find out if a specific drug is on our Drug List?

You have three ways to find out:

1. Check the most recent Drug List we provided electronically at **kp.org**.
2. Visit our website (**kp.org/seniorrx).** Our Drug List (**Kaiser Permanente 2020 Comprehensive Formulary**) on the website is always the most current.
3. Call Member Services to find out if a particular drug is on our plan's Drug List (**Kaiser Permanente 2020 Comprehensive Formulary**) or to ask for a copy of the list. Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 4. There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when we cover them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-

cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once on our Drug List (**Kaiser Permanente 2020 Comprehensive Formulary**). This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version. We usually will not cover the brand-name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan.

Section 4.3 Do any of these restrictions apply to your drugs?

Our plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website **(kp.org/seniorrx)**.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get

coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

SECTION 5. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by our plan have extra rules to restrict their use. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. Our plan puts each covered drug into one of six different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend upon what type of problem you have:

- If your drug is not on our Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on our Drug List or if the drug is restricted in some way?

If your drug is not on our Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask us to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, we can offer a temporary supply of a drug to you when your drug is not on our Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is no longer on our plan's Drug List.
- Or the drug you have been taking is now restricted in some way (Section 4 in this chapter tells you about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in our plan last year:** We will cover a temporary supply of your drug during the first 90 days of your membership in our plan if you are new and during the first 90 days of the calendar year if you were in our plan last year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in our plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:** We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- **For current members with level of care changes**, if you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may require an additional fill of your medication. We will generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our Drug List.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by our plan or ask us to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by our plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on our plan's Drug List. Or you can ask us to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception to the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our specialty tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6. What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, we might make changes to the Drug List. For example, we might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for

an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- Replace a brand-name drug with a generic drug.

We must follow Medicare requirements before we change our Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand-name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand-name drug)**
  - We may immediately remove a brand-name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
  - You or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
  - If you are taking the brand-name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand-name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.

- Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand-name drug or change the cost-sharing tier or add new restrictions to the brand-name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
- **Changes to drugs on the Drug List that will not affect people currently taking the drug:** For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in our plan:
  - If we move your drug into a higher cost-sharing tier.
  - If we put a new restriction on your use of the drug.
  - If we remove your drug from the Drug List.

If any of these changes happen to a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand-name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

SECTION 7. What types of drugs are not covered by our plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section; the only exception is if the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of

your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology; or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Nonprescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for the treatment of sexual or erectile dysfunction.
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8. Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill our plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call our plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1, for information about how to ask us for reimbursement.

SECTION 9. Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell you about the rules for getting drug coverage. The Medical Benefits Chart found at the front of this **EOC** gives you more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, "Ending your membership in our plan," tells you when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of our plan?

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of up to a 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of our plan for more than 90 days and need a drug that is not on our Drug List or if our plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by our plan that might work just as well for you. Or you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do.

Section 9.3 Special note about "creditable coverage"

Each year your employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage, from your employer or retiree group plan, you can get a copy from your employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D. Chapter 6, "What you pay for your Part D prescription drugs," gives more information about drug coverage and what you pay.

SECTION 10. Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.
- Unsafe amounts of opioid pain medications.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think

should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or you live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

CHAPTER 6. What you pay for your Part D prescription drugs

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered under your group's plan.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- Our **Kaiser Permanente 2020 Comprehensive Formulary**. To keep things simple, we call this the "**Drug List**."
  - This Drug List tells you which drugs are covered for you.
  - It also tells you which of the six "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at **kp.org/seniorrx**. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet**. Chapter 5 gives you the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells you which types of prescription drugs are not covered by our plan.

- **Our plan's Pharmacy Directory**. In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The **Pharmacy Directory** has a list of pharmacies in our plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The "deductible" is the amount you must pay for drugs before our plan begins to pay its share.
- "Copayment" means that you pay a fixed amount each time you fill a prescription.
- "Coinsurance" means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2. What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Senior Advantage members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends upon which of these stages you are in at the time you get a prescription filled or refilled. Stage 4 applies to everyone, but your group plan may not include a Deductible Stage (Stage 1) or a Coverage Gap Stage (Stage 3). Refer to the Medical Benefits Chart found at the front of this **EOC** to find out which stages apply to you. Keep in mind you are always responsible for our plan's monthly premium regardless of the drug payment stage.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage See the Medical Benefits Chart at the front of the **EOC** to find out if this payment stage applies to you. (This stage does not apply to most members.) If your plan has a deductible, during this stage, you pay the full cost of your drugs. You stay in this stage until you have paid your deductible. (Details are in Section 4 of this chapter.)	**Initial Coverage Stage** **If your plan has a deductible, you begin in this stage after you end the Deductible Stage.** **If your plan does not have a deductible, you begin in this stage when you fill your first prescription of the year.** During this stage, we pay our share of the cost of your drugs and you pay your share of the cost. If your plan has a Coverage Gap Stage, you stay in this stage until your year-to-date "**total drug costs**" (your payments plus any Part D plan's payments) total **$4,020**. If your plan does not have a Coverage Gap Stage, you stay in this stage until your year-to-date "**out-of-pocket costs**" (your payments) total **$6,350**. (Details are in Section 5 of this chapter.)	**Coverage Gap Stage** See the Medical Benefits Chart at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members). If there is no coverage gap for your plan, this payment stage does not apply to you. If this stage applies to you, coverage during the gap stage varies depending on the plan your group has selected. For **generic drugs, you pay either the copayment** listed in the Medical Benefits Chart at the front of this EOC, **or 25% of the price**, whichever is lower. For **brand-name drugs, you pay 25% of the price** (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of **$6,350**. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	**Catastrophic Coverage Stage** During this stage, **we will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2020). (Details are in Section 7 of this chapter.)

SECTION 3. We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the **Part D Explanation of Benefits** (it is sometimes called the "**Part D EOB**") when you have had one or more prescriptions filled through our plan during the previous month. It includes:

- **Information for that month.** This report gives you the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up-to-date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up-to-date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask us to pay our share of the cost. For instructions about how to do this, go to Chapter 7, Section 2, of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.

- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a **Part D Explanation of Benefits** (a **Part D EOB**) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also choose to view your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4. During the Deductible Stage, if applicable, you pay the full cost of your drugs

See the Medical Benefits Chart found at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members).

Section 4.1 If your plan includes a deductible for your Part D drugs

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount. Please refer to the Medical Benefits Chart found at the front of this **EOC** for the deductible amount.

- Your "**full cost**" is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The "**deductible**" is the amount you must pay for your Part D prescription drugs before our plan begins to pay its share.

Once you have paid the deductible amount shown in the Medical Benefits Chart found at the front of this **EOC**, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5. During the Initial Coverage Stage, we pay our share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends upon the drug and where you fill your prescription

During the Initial Coverage Stage, we pay our share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending upon the drug and where you fill your prescription.

Our plan has six cost-sharing tiers

Every drug on our plan's Drug List is in one of six cost-sharing tiers. Depending upon the plan your group has selected, cost-sharing may vary from one tier to the next. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs.
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs (this tier includes some generic drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends upon whether you get the drug from:

- A network retail pharmacy that offers a standard cost-sharing.
- A network retail pharmacy that offers preferred cost-sharing.
- A pharmacy that is not in our plan's network.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and our plan's **Pharmacy Directory**.

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing.

Section 5.2 Your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- "**Copayment**" means that you pay a fixed amount each time you fill a prescription.
- "**Coinsurance**" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the Medical Benefits Chart found at the front of this **EOC**, the amount of the copayment or coinsurance depends upon which cost-sharing tier your drug is in. **Please note:**

- If your covered drug costs less than the copayment amount listed in the Medical Benefits Chart found at the front of this **EOC**, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, for information about when we will cover a prescription filled at an out-of-network pharmacy.

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts and day supply limit in the Initial Coverage Stage.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 Your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts when you get a long-term (up to a 90-day) supply of a drug.

- **Please note:** If your covered drug costs less than the copayment amount listed in the Medical Benefits Chart found at the front of this **EOC**, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

Section 5.5 You stay in the Initial Coverage Stage until you reach the next stage

If your group plan does not include a Coverage Gap Stage, you stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$6,350**. When you reach an out-of-pocket limit of **$6,350**, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. Most group plans do not include a Coverage Gap Stage.

If your group plan includes a Coverage Gap Stage, you stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,020 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What our plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2020, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The **Part D Explanation of Benefits (Part D EOB)** that we send to you will help you keep track of how much you and our plan, as well as third parties have spent on your behalf during the year. Many people do not reach the **$4,020** limit in a year.

We will let you know if you reach this **$4,020** amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Refer to the Medical Benefits Chart found at the front of this **EOC** for the amount you will pay for drugs in the Coverage Gap Stage.

SECTION 6. During the Coverage Gap Stage, if applicable, we provide some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $6,350

The benefit coverage you receive during the Coverage Gap Stage will depend on the benefits your group selected. See the Medical Benefits Chart found at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members).

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs. You pay either the copayments listed in the Medical Benefits Chart found at the front of this EOC or 25% of the negotiated price and a portion of the dispensing fee for **brand-name drugs**. If you pay 25% of the negotiated price, both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap.

You also receive some coverage of generic drugs and injectable Part D vaccines during the Coverage Gap Stage. You pay either the copayments listed in the Medical Benefits Chart found at the front of this **EOC** or 25% of the costs of generic drugs, whichever is lower. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the applicable cost sharing until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2020, that amount is **$6,350.**

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of **$6,350**, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (if this stage applies to you).
  - The Initial Coverage Stage.
  - The Coverage Gap Stage (if this stage applies to you).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount we pay for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$6,350** in out-of-pocket costs within the calendar year, you will move from either the Initial Coverage Stage (if this stage applies to you) or the Coverage Gap Stage (if this stage applies to you) to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not** allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group's premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet our plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare prescription drug plan.

- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments made by our plan for your brand or generic drugs while in the Coverage Gap, if this stage applies to you.
- Payments for your drugs that are made by group health plans, including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The **Part D Explanation of Benefits (Part D EOB)** report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells you about this report). When you reach a total of **$6,350** in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells you what you can do to help make sure that our records of what you have spent are complete and up-to-date.

SECTION 7. During the Catastrophic Coverage Stage, we pay most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$6,350** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, we will pay most of the cost for your drugs.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is larger amount:

- Either, you pay a coinsurance of **5%** of the cost of the drug,
- Or, **$3.60** for a generic drug or a drug that is treated like a generic, and **$8.95** for all other drugs.

We will pay the rest of the cost.

SECTION 8. What you pay for vaccinations covered by Part D depends upon how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

We provide coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart found at the front of this **EOC**.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.
- The second part of coverage is for the cost of giving you the vaccine. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends upon three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the Medical Benefits Chart found at the front of this **EOC**.
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in our **Kaiser Permanente 2020 Comprehensive Formulary.**
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending upon the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask us to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine.

If your plan has a Deductible Stage, remember you are responsible for all of the costs associated with Part D vaccines (including their administration) during the Deductible Stage of your benefit.

Situation 1:

- You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to administer a vaccination.)
  - You will have to pay the pharmacy the amount of your copayment for the vaccine and the cost of giving you the vaccine.
  - Our plan will pay the remainder of the costs.

Situation 2:

- You get the Part D vaccination at your doctor's office.
  - When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
  - You can then ask us to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet ("Asking us to pay our share of a bill you have received for covered medical services or drugs").
  - You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).

Situation 3:

- You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.
  - You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
  - When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask us to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
  - You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you first call Member Services whenever you are planning to get a vaccination. Phone numbers for Member Services are printed on the back cover of this booklet.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

When you've received emergency or urgently needed medical care from a provider who is not in our network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

When a network provider sends you a bill you think you should not pay

Network providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we

don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

If you are retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5, to learn more.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on our **Kaiser Permanente 2020 Comprehensive Formulary**; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

SECTION 2. How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask for the form. Phone numbers for Member Services are printed on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

Kaiser Foundation Health Plan of Colorado
Claims Department
P.O. Box 373150
Denver, CO 80237-3150

You must submit your claim to us within 365 days of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3. We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the section in Chapter 9 that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4. Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage or Coverage Gap Stage (if your plan has one or both—refer to the Medical Benefits Chart found at the front of this **EOC***)*, you can buy your drug at a network pharmacy for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible or Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through our plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8. Your rights and responsibilities

SECTION 1. We must honor your rights as a member of our plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or CD)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. This booklet is available in Spanish by calling Member Services (phone numbers are on the back cover of this booklet). We can also give you information in Braille, large print, or CD at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227**) or directly with the Office for Civil Rights. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Member Services for additional information.

Sección 1.1 Debemos proporcionar la información de un modo adecuado para usted (en idiomas distintos al inglés, en Braille, en letra grande o en CD)

Para obtener información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de interpretación disponibles sin costo para responder las preguntas de los miembros discapacitados y que no hablan inglés. Este folleto está disponible en español o chino; llame a Servicio a los Miembros (los números de teléfono están en la contraportada de este folleto). Si la necesita, también podemos darle, sin costo, información en Braille, letra grande o CD. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener nuestra información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto) o comuníquese con nuestro Coordinador de Derechos Civiles.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, por favor llame para presentar una queja a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto). También puede presentar una queja en Medicare llamando al **1-800-MEDICARE (1-800-633-4227**) o directamente en la Oficina de Derechos Civiles. En esta Evidence of Coverage (**Evidencia de**

Cobertura) o en esta carta se incluye la información de contacto, o bien puede comunicarse con Servicio a los Miembros para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist), a mental health services provider, and a provider for routine eye exams without a referral, as well as other providers described in Chapter 3, Section 2.2.

As a plan member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10, of this booklet tells you what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4, tells you what you can do.)

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in our plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- Your health information is shared with your Group only with your authorization or as otherwise permitted by law.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish and in Braille, large print or CD.

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers, including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the **Provider Directory**.
  - For a list of the pharmacies in our network, see the **Pharmacy Directory**.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at **kp.org/directory**.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details about your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus our plan's Drug List. These chapters, together with the Drug List, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask us to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.5 We must treat you with dignity and respect and support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells you how to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form**. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Colorado Department of Public Health and Environment.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends upon the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.

- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare:
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at **https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
  - Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

Section 1.10 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions (phone numbers are printed on the back cover of this booklet).

SECTION 2. You have some responsibilities as a member of our plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered services.

- Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us**. Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and other health care providers that you are enrolled in our plan**. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**.
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate**. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B (or Medicare Part B). Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your medical services. The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your Part D prescription drugs.

- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a special enrollment period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information about how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Making complaints 159

Background

SECTION 1. Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," or "at-risk determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3, of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can visit the Medicare website (**https://www.medicare.gov**).

SECTION 3. To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help you with your specific problem or concern, *START HERE:*

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

- **Yes, my problem is about benefits or coverage:**

  Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

- **No, my problem is not about benefits or coverage:**

  Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

SECTION 4. A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals—*The big picture*

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say ***no*** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, **contact your State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **https://www.cms. gov/Medicare/CMS-Forms/CMS-**

Forms/downloads/cms1696.pdf or on our website at **kp.org**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** in this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."
- **Section 7** in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 8** in this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in the Medical Benefits Chart found at the front of this **EOC**. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells you what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan.
3. You have received medical care or services that you believe should be covered by our plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by our plan, and you want to ask us to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- **Chapter 9, Section 7:** "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Chapter 9, Section 8:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and (CORF) services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section in this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** in this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** in this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an "**organization determination**."

Step 1: **You ask us to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms
A "fast coverage decision" is called an "**expedited determination**."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making a complaint about your medical care."

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer **within 14 calendar days** after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** after we receive your request.

- However, for a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- A fast coverage decision means we will answer **within 72 hours** if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - However, for a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own, without your doctor's support,** we will decide whether your health requires that we give you a fast coverage decision.

- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

Step 2: **We consider your request for medical care coverage and give you our answer.**

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you our answer **within 72 hours** (or if there is an extended time period, by the end of that period), or **24 hours** if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- **If our answer is *yes* to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide **within 72 hours** after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is *no* to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days** of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make

the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
- If we do not give you our answer **within 14 calendar days** (or if there is an extended time period, by the end of that period) or **72 hours** if your request is for a Part B prescription drug,, you have the right to appeal. Section 5.3 below tells you how to make an appeal.

- **If our answer is *yes* to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide **within 14 calendar days,** or **72 hours** if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: **If we say *no* to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to our plan about a medical care coverage decision is called a plan "**reconsideration**."

Step 1: **You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."**

What to do:

- **To start an appeal, you, your doctor, or your representative must contact us.** For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."

- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at **https://www.cmsgov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an "**expedited reconsideration**."

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: **We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said ***no*** to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours** after we receive your appeal**.** We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer **within 72 hours** (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is *yes* to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide **within 72 hours** after we receive your appeal.
- **If our answer is *no* to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days for your request for a medical item or service), we are required to send your request on to Level 2

of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is *yes* to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide **within 30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug after we receive your appeal
- **If our answer is *no* to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: **If our plan says *no* to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said ***no*** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: **The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours of when it receives your appeal**.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: **The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says ***yes*** to part or all of a request for a medical item or service, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for standard requests or **within 72 hours** from the date we receive the decision from the review organization for expedited requests.
- If this organization says ***no*** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: **If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see the Medical Benefits Chart found at the front of this **EOC**. We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

We will say *yes* or *no* to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our **Kaiser Permanente 2020 Comprehensive Formulary**. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the **Kaiser Permanente 2020 Comprehensive Formulary**, rules and restrictions on coverage, and cost information, see Chapter 5 ("Using our plan's coverage for your Part D prescription drugs") and Chapter 6

("What you pay for your Part D prescription drugs") or the Medical Benefits Chart found at the front of this **EOC**.

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a "**coverage determination**."

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on our **Kaiser Permanente 2020 Comprehensive Formulary**.
  - Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get).
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our **Kaiser Permanente 2020 Comprehensive Formulary**, but we require you to get approval from us before we will cover it for you.
  - **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) **Start with Section 6.2 in this chapter.**
Do you want us to cover a drug on our Drug List and you believe you meet any plan	You can ask us for a coverage decision. **Skip ahead to Section 6.4 in this chapter.**

rules or restrictions (such as getting approval in advance) for the drug you need?	
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to Section 6.4 in this chapter.**
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to Section 6.5 in this chapter.**

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "**exception**." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Kaiser Permanente 2020 Comprehensive Formulary.** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception**."

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 (nonpreferred brand-name drugs). You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our **Kaiser Permanente 2020 Comprehensive Formulary** (for more information, go to Chapter 5 and look for Section 4).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception**."

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand-name drug.
  - Getting **plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier**. Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a "**tiering exception**."

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  - If the drug you're taking is a brand-name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand-name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "**alternative**" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say *yes* or *no* to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say ***no*** to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: **You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do:

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the section called "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the

statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

Legal Terms
A "fast coverage decision" is called an "**expedited coverage determination**."

If your health requires it, ask us to give you a "fast coverage decision"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer **within 72 hours after we receive your doctor's statement**. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own** (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 in this chapter.)

Step 2: **We consider your request and we give you our answer.**

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

- Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is *yes* to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is *yes* to part or all of what you requested**:
  - If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is *yes* to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.

- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: **If we say *no* to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to our plan about a Part D drug coverage decision is called a plan "**redetermination**."

Step 1: **You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."**

What to do:

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details about how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1,** "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.

- If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms
A "fast appeal" is also called an "**expedited redetermination**."

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: **We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said ***no*** to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is *yes* to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said ***no*** and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal for a drug you have not received yet**. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a “fast appeal”.
- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is *yes* to part or all of what you requested**:

- If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
- If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.

- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said ***no*** and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is *yes* to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is *no* to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: **If we say *no* to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.**

- If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said ***no*** to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: **To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.**

- If we say ***no*** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These

instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: **The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours after it receives your appeal request**.
- If the Independent Review Organization says ***yes*** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days after it receives your appeal** if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal within 14 calendar days after it receives your request.
- If the Independent Review Organization says ***yes*** to part or all of what you requested:
  - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says *no* to your appeal?

If this organization says ***no*** to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: **If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the Medical Benefits Chart found at the front of this **EOC**.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can "**request an immediate review**." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

- **You must sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.
- **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE** (**1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see it online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: **Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (**An Important Message from Medicare About Your Rights**) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - **If you meet this deadline,** you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - **If you do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "fast review" is also called an "**immediate review**" or an "**expedited review**."

Step 2: **The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons

why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge**." You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or you can see a sample notice online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Step 3: **Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

*What happens if the answer is **yes**?*

- If the review organization says ***yes*** to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Medical Benefits Chart found at the front of this **EOC**.)

*What happens if the answer is **no**?*

- If the review organization says ***no*** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your **inpatient hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says ***no*** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost of hospital care** you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: **If the answer to your Level 1 Appeal is *no*, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down

your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeals process:

Step 1: **You contact the Quality Improvement Organization again and ask for another review.**

- **You must ask for this review within 60 calendar days** after the day the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: **The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: **Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

*If the review organization says **yes**:*

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

*If the review organization says **no**:*

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 4: **If the answer is *no*, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, **go to Chapter 2**, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say *no* to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said ***no*** to your fast appeal**,** we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this **organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are

coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say ***no*** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is **only** about the following types of care:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see the Medical Benefits Chart found at the front of this **EOC**.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a "**fast-track appeal.**" Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells you how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048.**) Or see a copy online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html**.

- You must sign the written notice to show that you received it.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with us that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 in this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: **Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5 in this chapter.

Step 2: **The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage

for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage**."

Step 3: **Within one full day after they have all the information they need, the reviewers will tell you their decision.**

*What happens if the reviewers say **yes** to your appeal?*

- If the reviewers say ***yes*** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Medical Benefits Chart found at the front of this **EOC**).

*What happens if the reviewers say **no** to your appeal?*

- If the reviewers say ***no*** to your appeal, then **your coverage will end** on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **then you will have to pay the full cost of this care yourself**.

Step 4: **If the answer to your Level 1 Appeal is *no*, you decide if you want to make another appeal.**

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another

look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeals process:

Step 1: **You contact the Quality Improvement Organization again and ask for another review.**

- **You must ask for this review within 60 days** after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: **The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: **Within 14 days of receipt of your appeal request reviewers will decide on your appeal and tell you their decision.**

*What happens if the review organization says **yes** to your appeal?*

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

*What happens if the review organization says **no**?*

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 4: **If the answer is *no*, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say *no* to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself**.

*Step 4: If we say **no** to your fast appeal, your case will automatically go on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal, **we are required to send your appeal to the Independent Review Organization**. When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The **Independent Review Organization** is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary.

You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 9. Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the administrative law judge or attorney adjudicator says *yes* to your appeal, the appeals process may or may *not* be over.** We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **not** to appeal the decision, we must authorize or provide you with the service **within 60 calendar days** after receiving the administrative law judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the administrative law judge or attorney adjudicator says *no* to your appeal, the appeals process may or may *not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is *yes*, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may *not* be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service **within 60 calendar days** after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is *no* or if the Council denies the review request, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is *yes*, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge or attorney adjudicator **within 72 hours** (**24 hours** for expedited appeals) or make payment no later than **30 calendar days** after we receive the decision.
- **If the answer is *no*, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is *yes*, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Council **within 72 hours** (**24 hours** for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is *no*, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Making complaints

SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is **only** used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint":

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Services has treated you?
  - Do you feel you are being encouraged to leave our plan?
- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
- **Cleanliness**

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

- **Information you get from our plan**
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4–9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a "complaint" is also called a "grievance."
- Another term for "making a complaint" is "filing a grievance."
- Another way to say "using the process for complaints" is "using the process for filing a grievance."

Section 10.3 Step-by-step: Making a complaint

Step 1: **Contact us promptly—either by phone or in writing.**

- **Usually calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call toll-free **1-800-476-2167 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.
- **If you have a complaint, we will try to resolve your complaint over the phone**. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint.
    We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours.
- **Whether you call or write, you should contact Member Services right away.**
  The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision"**
  or a "fast appeal," we will automatically give you a "fast complaint."
  If you have a "fast complaint," it means we will give you an answer **within 24 hours**.

Legal Terms
What this section calls a "**fast complaint**" is also called an "**expedited grievance**."

Step 2: **We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

CHAPTER 10. Ending your membership in our plan

SECTION 1. Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- **You might leave our plan because you have decided that you want to leave.**
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in our plan. Section 2 tells you when you can end your membership in our plan.
  - The process for voluntarily ending your membership varies depending upon what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2. When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave our plan during your group's open enrollment period. In certain situations, you may also be eligible to leave our plan at other times of the year. Before you request disenrollment, please check with your group to determine if you are able to continue your group membership.

If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

Section 2.1 Where can you get more information about when you can end your group membership?

If you have any questions or would like more information about when you can end your group membership:

- Contact your group's benefits administrator.
- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You 2020** handbook.
  - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (**https://www.medicare.gov**). Or you can order a printed copy by calling Medicare at the number below.

You can contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 3. How do you end your membership in our plan?

Section 3.1 There are several ways to end your Senior Advantage membership

You may request disenrollment by:

- Requesting disenrollment with your group's benefits administrator. You should always consult them before taking any action because it can affect your eligibility for group benefits.
- Calling toll-free **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048,** or
- Sending written notice to the following address:

  Kaiser Foundation Health Plan, Inc.
  California Service Center
  P.O. Box 232407
  San Diego, CA 92193-2400

SECTION 4. Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information about when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5. We must end your membership in our plan in certain situations

Section 5.1 When must we end your membership in our plan?

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and/or Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.

- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information about when we can end your membership:

- You can call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10, for information about how to make a complaint.

Section 5.4 What happens if you are no longer eligible for group coverage?

After your group notifies us to terminate your group membership, we will send a termination letter to the subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

- If you are no longer eligible for group membership, you can request enrollment in our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this **Evidence of Coverage** and will include Medicare Part D prescription drug coverage.
- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5.1. For more information or

information about other individual plans, call Member Services. Phone numbers are printed on the back cover of this booklet.

CHAPTER 11. Legal notices

SECTION 1. Notice about governing law

Many laws apply to this **Evidence of Coverage** and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2. Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY **1-800-537-7697**) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3. Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

SECTION 5. Amendment of this Agreement

Your group's Agreement with us will change periodically. If these changes affect this **Evidence of Coverage**, your group is required to inform you in accord with applicable law and your group's Agreement.

SECTION 6. Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this **Evidence of Coverage**.

SECTION 7. Assignment

You may not assign this **Evidence of Coverage** or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 8. Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses except as otherwise required by law.

SECTION 9. Coordination of benefits

As described in Chapter 1 (Section 10) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For

more information about primary payments in third party liability situations, see Section 18, and for primary payments in workers' compensation cases, see Section 20.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

SECTION 10. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

SECTION 11. Evidence of Coverage binding on members

By electing coverage or accepting benefits under this **Evidence of Coverage**, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this **Evidence of Coverage**.

SECTION 12. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 13. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

SECTION 14. No waiver

Our failure to enforce any provision of this **Evidence of Coverage** will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

SECTION 15. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this booklet) and Social Security at **1-800-772-1213 (TTY 1-800-325-0778)** as soon as possible to report your address change.

Note: When we tell your group about changes to this **Evidence of Coverage** or provide your group other information that affects you, your group is required to notify the subscriber within 30 calendar days (or five days if we terminate your group's Agreement) after receiving the information from us.

SECTION 16. Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

SECTION 17. Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

SECTION 18. Third party liability

As stated in Chapter 1, Section 10, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services. Note: This Section 18 does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, worker's compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Patient Business Services

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, CO 80014-1622

Please contact our Patient Business Services Department at **303-743-5900,** or TTY users may call **711**.

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

SECTION 19. U.S. Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

SECTION 20. Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 10, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.

From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

CHAPTER 12. Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the annual out-of-pocket maximum.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit when you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent **$6,350** in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles, if applicable. Coinsurance is usually a percentage (for example, 20%) of Plan Charges.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of

care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 10) and Chapter 11 (Section 9) for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. Note: In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you may pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the copayment when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Dependent–A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Condition – Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a plan hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a nonpreferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if we limit the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Drug – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family – A subscriber and all of his or her dependents.

Formulary – A list of Medicare Part D drugs covered by our plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Group – The entity with which we have entered into the *Agreement* that includes this **Evidence of Coverage**.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart found at the front of this **EOC**. We cover home health care in accord with Medicare guidelines. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically

necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5 % of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible, if applicable, and before your total drug costs, including amounts you have paid and what your plan has paid on your behalf, for the year have reached **$4,020**.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan of Colorado (Health Plan) – Kaiser Foundation Health Plan of Colorado is a Colorado nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Kaiser Foundation Health Plan of Colorado and the Medical Group.

Kaiser Permanente 2020 Comprehensive Formulary (Formulary or "Drug List") – A list of prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Kaiser Permanente Region – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente region's service area. For more information, please refer to Chapter 3, Section 2.2.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for any contributions

toward your group's monthly premium, your Medicare Part A and Part B premiums, and Part D prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Colorado Permanente Medical Group, P.C., a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services and **Customer Experience** – Departments within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services and Customer Experience.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, (including but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. We play network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your

share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this **Evidence of Coverage**, *most drugs you get from out-of-network pharmacies are not covered b*y our plan unless certain conditions apply (see Chapter 5, Section 2.5, for more information).

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Plan – Kaiser Permanente Senior Advantage.

Plan Charges – Plan Charges means the following:

- For services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.
- For services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.

- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about primary care providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this **EOC** and described in Chapter 3, Section 2.3. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial

limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Spouse – Your legal husband or wife.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-476-2167** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente does has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2500 South Havana, Aurora, CO 80014 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-476-2167** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-476-2167** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-476-2167**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-476-2167** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-476-2167** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-476-2167 (TTY: **711**)번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-476-2167** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-476-2167（TTY:**711**）まで、お電話にてご連絡ください。

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-476-2167** (መስማት ለተሳናቸው: **711**).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-476-2167** (TTY: **711**).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-476-2167** (ATS : **711**).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-476-2167 (TTY: 711)** تماس بگیرید.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-674-7612** (رقم هاتف الصم والبكم: **117**-).

Yoruba
AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-476-2167** (TTY: **711**).

Cushite-Oromo
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-476-2167** (TTY: **711**).

Nepali
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् **1-800-476-2167** (टिटिवाइ: **711**) ।

ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for both same- and opposite-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same- and opposite-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMPA0AA (01-18)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Spouse and eligible Dependent children may continue coverage in the Group, if they wish.

SRDC0AK (01-08)
WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

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

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage

Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted providers. Coverage includes:

a. Evaluation;
b. Manual and manipulative therapy of the spinal and extraspinal regions.

You may self-refer for visits to contracted providers.

Note: The following are covered, but not under this section: X-ray and laboratory tests, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

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

CHIR0AA (01-18) DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions
   i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
   ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
   iii. Non-medical items such as sauna baths or elevators.
   iv. Exercise or hygiene equipment.
   v. Comfort, convenience, or luxury equipment or features.
   vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
   *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
   vii. Replacement of lost or stolen equipment.
   viii. Repairs, adjustments, or replacements necessitated by misuse.
   ix. More than one piece of DME serving essentially the same function, except for replacements.
   x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
   Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.

   b. Prosthetic Devices Exclusions
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost or stolen prosthetic devices.
      vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
   Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless you are covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

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

OPT0AB

OPTICAL BENEFIT

1. Coverage

   A credit, as shown in the "Vision Services and Optical" section of the "Schedule of Benefits (Who Pays What)," applies toward the purchase of one pair of: (i) regular lenses; (ii) frames; or (iii) contact lenses, including cosmetic lenses, when obtained at a Plan Medical Office and prescribed by a physician or an optometrist. This includes: a $60 replacement credit for single vision and contact lenses; and $90 replacement credit for multifocal lenses if a Member's prescription changes .50 diopter or more within 12 months of the initial exam.

   Covered Services include:
   a. The frame;
   b. Mounting of lenses in the frames; and
   c. The original fitting and subsequent adjustment of the frame.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional charge, when obtained at Plan Medical Offices.

2. Exclusions

   Replacement of lost or broken lenses or frames.

This rider amends the EOC to provide optical hardware coverage. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

OPT0AB (01-20)
SNKR0AA

SILVER SNEAKERS FITNESS BENEFIT

A health and fitness benefit is covered and provided at participating fitness or wellness facilities within our Service Area. Health and fitness benefits include:

1. Fitness classes (to improve posture, flexibility and strength).
2. Toning with weights.
3. Aerobic classes.
4. Circuit training.

Additional benefits provided at some facilities include:

1. Swimming.
2. Court sports.
3. Running tracks.
4. Saunas.

You may access Services by taking your current Plan Identification Card to one of the participating fitness facilities within our Service Area and enrolling in the program. To get a list of the participating facilities, please call **Member Services.**

You will be given a one-time activity readiness assessment. Participation in the Fitness Benefit program is dependent upon the result of this assessment and may require a subsequent evaluation at a Plan Medical Office. There is no initiation fee and no monthly dues for participation.

Programs, Services and facilities which carry additional charges such as:

1. Racquetball;
2. Tennis and other court sports;
3. Massage therapy;
4. Lessons related to recreational sports;
5. Tournaments; and
6. Similar fee-based activities;

are excluded.

SNKR0AA (01-12)

ELECTIVE ABORTION EXCLUSION

Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are:

1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or
2. When the pregnancy is the result of an act of rape or incest; or
3. Treatment of complications following an abortion.

TABS0AA (01-12)

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KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**

Colorado State Health Insurance Assistance Program

Colorado State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	Contact information
CALL	**1-888-696-7213**
WRITE	SHIP, Colorado Division of Insurance 1650 Broadway Street, Suite 850 Denver, CO 80202
WEBSITE	**https://www.dora.state.co.us/insurance/senior/senior.htm**

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

4**********SNGLP

S1 P1 019005710580

HOHN PAULINE
4430 S ADAMS CO PKWY #C4000B
COUNTY OF ADAMS
BRIGHTON CO 80601

Important plan information

000000385 002 EMBC K NQ R CD GP 2_20 [Apr 27 2020] OVCUIHOSP2EBLDFIMHOP89SPVC9MOPTM3CDOPG3HEARGYEMER39PV51AFTR9KACUMCLALG6MALGTNAAMB0FAUTB--CDIP13CDRR49CHIRMECMPL--COIN--CRCS07DEDNADEN--DIAL0MDMEB41DMES78DPP--DUMY01EMPH4DEPOT--EXAB--FAM11FRST--GRPM1GYN8CHC02HCSS45HH0MHOOP3EHOS208HRA--INFT6MLAB56MHBI02MHBO01MHIP48OPMM2OVC22AOXYG31PNMT0MPP--REHB13REOPM5SGOP3GSNFMSNKRSSSTU--TABS17TRAN0MTRGN33TRVL--VADD--WLCH50XPRO27XRAY7MCDOPG3MHOP89HEARGYSPVC9MOVCUIRX04FIAPO45DMPA01GLISGMGREX01GRFD02OAD6MOAS6MSRDC11SV03WORAY

AMENDMENT ONE
2020 GROUP AGREEMENT

This document amends the January 1, 2020, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled "**Eligibility**" is hereby amended with the addition of the following language:

An Eligible Person is defined as –

A regular full-time employee or project designated employee of the Group who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Group who is scheduled to work at his or her job at least 30 hours per week.

Designated elected officials who are serving in an active capacity.

A retired person, as defined by the Group, who resides within the state of Colorado or maintains a permanent residency within the state of Colorado.

Retirees over 65 years of age, actively enrolled in Medicare, are not eligible for coverage.

Eligible Dependent(s) are defined as –

Your legal spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required)

Civil Union Partners (a copy of the Civil Union certificate is required)

Domestic Partners (a copy of the Domestic Partnership certificate is required)

Your or your Spouse's/Partner's child/children under the age of 26 (proof of dependency for a child over the age of 19 is not required).

A child born as a result of a Member acting as a gestational carrier is not an eligible Dependent under the terms of this plan unless the Subscriber or Spouse is the legal guardian of the child. Proof of legal guardianship is required.

A child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or court order.

The section titled "**Miscellaneous Provisions**" is hereby amended with the addition of the following language:

Group requires retirees covered under the commercial plan; who live in Colorado but reside outside the Denver/Boulder or Northern Colorado Service Areas, to obtain all routine care at Kaiser Permanente Medical Office Buildings located in Denver/Boulder, Southern Colorado, or Northern Colorado Service Areas only. Group requires those retirees to receive hospital services at contracted hospitals in their Service Area.

Medicare is primary after 30 months from the date of the first dialysis, for active employees and dependents of active employees who qualify for Medicare due to End Stage Renal Disease (ESRD), therefore Medicare Combo Rates are included in the contract.

For Members entitled to Medicare, Medicare is the primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and Medicare coverage be secondary.

Medicare is primary after 30 months from the date of the first dialysis, for active employees and dependents of active employees who qualify for Medicare due to End Stage Renal Disease (ESRD), therefore Medicare Combo Rates are included in the contract.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2020
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2020

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2020

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY

AMENDMENT TWO
2020 GROUP AGREEMENT
MEDICARE LOW INCOME SUBSIDY (LIS)

This document amends the January 1, 2020, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled "**Subscriber Contributions for Medicare Part D Coverage**" is hereby amended with the addition of the following language:

- Health Plan will mail monthly Low Income Subsidy refund payments for that portion of its Senior Advantage health care premium representing prescription drug coverage provided pursuant to Medicare Part D.
- These Low Income Subsidy payments will be mailed directly to Members enrolled in Kaiser Permanente Senior Advantage health plans.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 1, 2020
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2020

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2020

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY

AMENDMENT THREE
2020 GROUP AGREEMENT
SENIOR ADVANTAGE MEDICARE

This document amends the January 1, 2020, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled "**Group Eligibility Requirements**" is hereby amended with the addition of the following language:

An Eligible Person is defined as –

A retired person, as defined by the Group, their eligible dependents, and the eligible dependents of active employees as provided under applicable law, who reside within the applicable service area as defined in the Evidence of Coverage for Senior Advantage and are actively enrolled in Medicare A & B.

An eligible person does not include foster children

The section titled "Surrogacy" is hereby amended with the addition of the following language:
A child born as a result of a Member acting as a gestational carrier/surrogate is not an eligible Dependent under the terms of the plan unless the Subscriber or Spouse is the legal guardian of the child. Proof of legal guardianship must be submitted to the Group.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2020
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2020

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2020

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY

GA-County Adams(M)Amend (01-20)

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: 2020 United Healthcare Contracts
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: October 15, 2019
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves the 2020 Financial Renewal and Terms Amendment to the Administrative Services Agreement, the Amendment to the Specific Excess Risk Insurance Policy, and the Summary Plan Descriptions with United Healthcare Services, Inc.

BACKGROUND: The Adams County Board of County Commissioners entered into a contract with United HealthCare Services Inc., to provide Third Party Administration and Specific Excess Risk Insurance for the county's self-funded health plan.

The attached Financial Renewal and Terms Amendment to the Administrative Services Agreement between United HealthCare, Services Inc. and County of Adams provides for changes to the Financial Terms as outlined within Exhibit A and changes to the Performance Standards as outlined within Exhibit B, providing consistent performance reimbursement guarantees for 2020.

The attached Amendment to the Specific Excess Loss Insurance Policy provides for changes as outlined in the Schedule of Benefits.

The attached United HealthCare Summary Plan Descriptions provide for the addition of Hearing Aid coverage for 2020 and changes to the Eligibility rules as approved through Study Session.

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

ATTACHED DOCUMENTS:
Financial Renewal and Terms Amendment (Exhibit A and Exhibit B)
Stop Loss Amendment No. 7
Fully Executed Business Associate Agreement as reference in the Financial Renewal and Terms Amendment
UHC Choice EPO Plan Summary Plan Description
UHC Choice Plus HDHP/HSA Plan Summary Plan Description
UHC Colorado Doctors Plan (CDP) Summary Plan Description

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8612,8613

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION ADOPTING AMENDMENTS TO ADAMS COUNTY'S CONTRACTS WITH UNITED HEALTHCARE SERVICES

WHEREAS, the Adams County Board of County Commissioners previously entered into a contract with United HealthCare Services Inc. to provide Third Party Administration and Specific Excess Risk Insurance for the county's self-funded health plan; and,

WHEREAS, the attached Financial Renewal and Terms Amendment to the Administrative Services Agreement between United HealthCare, Services Inc. and County of Adams ("Financial Renewal and Terms Amendment") provides for changes to the Financial Terms as outlined in the attached Exhibit A and changes to the Performance Standards as outlined in the attached Exhibit B, providing consistent performance reimbursement guarantees; and,

WHEREAS, except as stated in the Financial Renewal and Terms Amendment and the Amended Non-Financial Terms, all terms and conditions of the original Administrative Services Agreement between United HealthCare, Services Inc. and County of Adams shall remain in full force and effect through December 31, 2020; and,

WHEREAS, the Adams County Board of County Commissioners recognizes the importance of obtaining additional excess risk insurance to mitigate the limit of liability for claims associated with the county's self-funded health plan; and,

WHEREAS, the attached Amendment to the Specific Excess Loss Insurance Policy ("Amendment No. 7") provides for changes as outlined in the United HealthCare Schedule of Benefits; and,

WHEREAS, the attached United HealthCare Choice EPO, Choice Plus HDHP/HSA, and Colorado Doctors Plan (CDP) Summary Plan Descriptions outline the Benefits provided under the contract, and are in effect through December 31, 2020; and,

WHEREAS, the following attached documents constitute the Amendments to Adams County's contracts with United HealthCare Services for the 2020 plan year:

1. Financial Renewal and Terms Amendment (Exhibit A and Exhibit B)
2. Stop Loss Amendment No. 7
3. Fully Executed Business Associate Agreement as reference in the Financial Renewal and Terms Amendment
4. UHC Choice EPO Plan Summary Plan Description
5. UHC Choice Plus HDHP/HSA Plan Summary Plan Description
6. UHC Colorado Doctors Plan (CDP) Summary Plan Description

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Amendments to Adams County's contracts with United HealthCare Services.

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

FINANCIAL RENEWAL AND TERMS AMENDMENT

This Amendment ("Amendment") is made to the Administrative Services Agreement ("Agreement") by and between United HealthCare Services, Inc. ("United") and Adams County Government ("Customer"), Contract No. 701043, and is effective on January 1, 2020 unless otherwise specified.

Any capitalized terms used in this Amendment have the meanings shown in the Agreement. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

The agreements that are being amended include any and all amendments, if any, that are effective prior to the effective date of this Amendment.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the agreements other than as stated herein.

The parties, by signing below, agree to amend the agreements as contained herein.

Adams County Government

By _____
Authorized Signature

Print Name _____

Print Title _____

Date _____

United HealthCare Services, Inc.

By _____
Authorized Signature

Print Name _____

Print Title _____

Date _____

APPROVED AS TO FORM
COUNTY ATTORNEY

EXHIBIT A

THE AMENDED FINANCIAL TERMS ARE AS FOLLOWS:

This Exhibit A shall not alter, vary, or affect any previously agreed to financial terms that are not amended by this Exhibit A.

Contract Number: 701043
The following financial terms are effective for the period January 1, 2020 through December 31, 2022.

The Standard Medical Service Fees are the sum of the following:

The Standard Medical Service Fees are as stated below. These fees do not include state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or United, including but not limited to those imposed pursuant to The Patient Protection and Affordable Care Act of 2010, as amended from time to time as these are the responsibility of the Plan. The Standard Medical Fees are based upon an estimated minimum of 837 enrolled Employees in 2020.

Effective January 1, 2020 through December 31, 2022

- $28.66 per Employee per month for the Choice and Choice Plus HSA portions of the Plan.
- $31.66 per Employee per month for the Choice CDP portion of the Plan.

Average Contract Size: 2.15 in 2020

Pharmacy AWP Contract Rate

Customer's contract rate for prescription drugs is as provided in Exhibit B. United uses Medi-Span's national drug data file as the source for Average Wholesale Price information. United reserves the right to revise the pricing and adopt a new source or benchmark if there are material industry changes in pricing methodologies. United will not use two or more pricing sources simultaneously for a given claim.

The optional and non-standard fees are the sum of the following

Service Description	Fee
Fraud and Abuse Management	Fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount
Hospital Audit Program Services	Fee not to exceed thirty-one percent (31%) of the gross recovery amount
Credit Balance Recovery Services	Fee not to exceed ten percent (10%) of the gross recovery amount.
Standardized Summary of Benefits and Coverage (SBC) as established under The Patient Protection and Affordable Care Act of 2010	United will provide, at no additional charge, standard format, electronic copies of the SBC documents (twice per year) for medical benefit plans administered by United. Customer logos can be included on the SBC at no additional charge. Additional fees will apply for other services. United will not create SBCs for medical plans United does not administer.
Third Party Liability Recovery (Subrogation) Services	Fee equal to thirty-three and one-third percent (33.3%) of the gross recovery amount
Shared Savings Program	The savings used to calculate the fee per individual claim for Shared Savings will not exceed $50,000. Accordingly, the fee per individual claim will not exceed 35% of $50,000. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.
Advanced Analytics and Recovery Services	Fee equal to twenty four percent (24%) of the gross recovery amount
HSA	$2.75 PEPM – Waived if average balance is $3,000 or more $2.50 per ATM transaction $20.00 per Outbound transfer or rollover to another HSA Custodian
Recovery Process Services **(Effective January 1, 2020)**	Attorneys' fees and costs directly incurred in connection with litigation or arbitration to recover any Overpayments will be deducted from the gross

	recovery. United will retain 32.5% of Customer's remaining recovery as a fee for its recovery process services. Customer's net recovery will be remitted to the Customer. No fees will be charged if the Overpayment is solely the result of United's acts.
Recovery Process – Non-Opt-Out Class Action Recoveries **(Effective January 1, 2020)**	No fee will apply for recoveries obtained through a class action where United does not file an opt-out case on behalf of Customer.

EXHIBIT B - PERFORMANCE GUARANTEES FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, as described in Exhibit B), (hereinafter referred to as "Fees") payable by Customer under this Agreement will be adjusted through a credit to its Service Fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2019 through December 31, 2020 (each twelve month period is a "Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

These guarantees will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date this Agreement is signed by both parties. In the event these guarantees become effective later than the effective date of the Guarantee Period: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the Agreement Period during which this Agreement is signed by both parties.

United reserves the right from time to time to replace any report or change the format of any report referenced in these guarantees. In such event, the guarantees will be modified to the degree necessary to carry out the intent of the parties. United shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent United's failure is due to Customer's actions or inactions or if United fails to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or United's required compliance with any law, regulation, or governmental agency mandate or anything beyond United's reasonable control.

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, United may specify to Customer in writing new performance guarantees for the subsequent Guarantee Period. If United specifies new performance guarantees, United will also provide Customer with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Effective January 1, 2020 through December 31, 2020

Claim Operations			
Time to Process in 10 Days			
Definition	The percentage of all claims United receives will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
Criteria	Standard claim operations reports		
Level	Site Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$3,143
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	11 business days 12 business days 13 business days 14 business days		

	15 business days or more		
Procedural Accuracy			
Definition	Procedural accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors		97%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$3,143
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%		
Dollar Accuracy (DAR)			
Definition	Dollar accuracy rate of not less than the designated percent in any quarter.		
Measurement	Percentage of claims dollars processed accurately		99%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars paid.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$3,143
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	98.99% - 98.50% 98.49% - 98.00% 97.99% - 97.50% 97.49% - 97.00 Below 97.00%		
Member Phone Service			
Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Customer's Participants. If Customer elects a specialized phone service model the results may be blended with more than one call center and/or level. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy (except when United is Customer's pharmacy benefit services administrator), dental, vision, Health Savings Account, etc.			
Average Speed of Answer			
Definition	Calls will sequence through our phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$3,143
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds		
Abandonment Rate			
Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		2%
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		

Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$3,143
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% Greater than 4.00%		
Call Quality Score			
Definition	Maintain a call quality score of not less than the percent set forth		
Measurement	Call quality score to meet or exceed		93%
Criteria	Random sampling of calls are each assigned a customer service quality score, using our standard internal call quality assurance program.		
Level	Office that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$3,143
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%		
Satisfaction			
Employee (Member) Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads "Overall, how satisfied are you with the way we administer your medical health insurance plan?"		
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher		80%
Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.		
Level	Office that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$1,571
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Customer Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads "How satisfied are you overall with UnitedHealthcare?"		
Measurement	Minimum score on a 10 point scale	score	5
Criteria	Standard Customer Scorecard Survey		
Level	Customer specific		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$1,571
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		

Effective January 1, 2020 through December 31, 2022 (each twelve month period is a "Guarantee Period")

Pharmacy Financials	
Definition	Contracted pharmacy rates that will be delivered to You.

Measurement and Criteria		**01/01/2020**	**01/01/2021**	**01/01/2022**
	Combined Discount Guarantee			
	Retail Brand, Average Wholesale Price (AWP) less	18.0%	18.0%	18.0%
	Retail Generic, AWP less	82.0%	82.0%	82.0%
	Mail Order Brand, AWP less	25.0%	25.0%	25.0%
	Mail Order Generic, AWP less	86.0%	86.0%	86.0%
	The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component and adding the amounts together.			
	Dispensing Fees			
	Retail Brand	$0.80	$0.80	$0.80
	Retail Generic	$0.80	$0.80	$0.80
	Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.			
Level	Customer Specific			
Period	Annually			
Payment Period	Annually			
Payment Amount -- Discounts	The amount the actual discounts are less than the combined guaranteed Retail, Mail, and Specialty discount amount.			
Payment Amount -- Dispensing Fees	The amount the combined actual dispensing fee exceeds the combined contracted dispensing fee.			
Conditions	**Discount Specific Conditions** • Discounts are based on actual Network Pharmacy brand and generic usage of retail and mail order drugs. The guaranteed discount amount will be determined by multiplying the AWP by the contracted discount rate off AWP by component. • Does not apply to items covered under the Plan for which no AWP measure exists. • Discounts calculated based on AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail and mail order generic prescriptions represent the average AWP based on savings off Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • The arrangement excludes generic medications launched as an 'at-risk' product, generic medication with pending litigation, compound drugs, retail out of network claims, mail order drugs (for dispensing fee arrangement) and non-drug items. • The Arrangement includes usual & customary claims, vaccines, long term care facility claims, veterans' affairs facility claims, over-the-counter claims. • The retail and mail order generic discounts exclude any generic drug that has two or fewer generic manufacturers; the retail and mail order brand discounts include any generic drug that has two or fewer generic manufacturers. • Specialty drugs dispensed out-of-network are included in the retail guarantees. Specialty drugs dispensed in-network are excluded from the Retail and Mail guarantees. • Drugs in the following Specialty therapeutic categories are included in the retail guarantees: HIV. • If Customer terminates pharmacy benefit services with United prior to 12/31/2022, United will retain any and all pending or future Rebates payable under the Agreement as of the effective date of the termination of pharmacy benefit services. **General Conditions** • On mail order drugs and retail pharmacy drugs and services including dispensing fees, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.			

TRRX (04/2019)	• A minimum of 753 Employees and 1,618 Participants enrolled in the pharmacy plan is required. • The lessor of three logic (non-ZBL) will apply to Participant payments. Participants pay the lessor of the discounted price, the usual and customary charge or the cost share amount. • All pricing guarantees require the selection of United as the exclusive mail provider. • United reserves the right to revise or revoke this arrangement if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in these arrangements; c) Customer makes benefit changes that impact the arrangements; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark; e) it is not accepted within ninety (90) days of the issuance of our initial quote; f) if Customer changes their mail service benefit.

Effective January 1, 2020 through December 31, 2022 (each twelve month period is a "Guarantee Period")

Specialty Pharmacy	
Specialty Pharmacy Discount Guarantee	
Definition	Specialty drug discount level based on actual specialty drug utilization for the specialty drugs dispensed through United's specialty Pharmacy Network
Measurement	Discount targets for individual drugs dispensed through United's specialty Pharmacy Network. See chart below.
Criteria	Actual utilization, using Average Wholesale Price (AWP) in dollars, using our data, of specialty drugs through Our specialty Pharmacy Network will be multiplied against the discount targets for the individual drugs to determine the overall discount target dollars. This total will be compared to actual discounts achieved for these drugs during the Guarantee Period.
Level	Customer Specific
Period	Annual
Payment Period	Annual
Payment Amount	The amount the actual discounts are less than the combined guaranteed Retail, Mail, and Specialty discount amount.
Conditions	• Discounts calculated based on the AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail generic prescriptions represent the average savings off AWP based on Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • Specialty drugs dispensed outside United's specialty Pharmacy Network, drugs for which no AWP measure exists and non-drug items are excluded. • United reserves the right to revise or revoke this guarantee if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in this guarantee; c) Customer makes benefit changes that impact the guarantee; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark • On specialty drugs, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.

Specialty Drug Category	Drug Name	Guarantee Pricing (AWP-%)	Specialty Drug Category	Drug Name	Guarantee Pricing (AWP-%)
ANEMIA	ARANESP	14.2%	INFLAMMATORY CONDITIONS	ACTEMRA	14.2%
ANEMIA	EPOGEN	13.3%	INFLAMMATORY CONDITIONS	CIMZIA	15.5%
ANEMIA	PROCRIT	13.6%	INFLAMMATORY CONDITIONS	COSENTYX	13.0%

ANEMIA	RETACRIT	14.1%	INFLAMMATORY CONDITIONS	DUPIXENT	14.1%
ANTICONVULSANTS	EPIDIOLEX	12.5%	INFLAMMATORY CONDITIONS	EMFLAZA	10.9%
ANTIHYPERLIPIDEMIC	JUXTAPID	13.2%	INFLAMMATORY CONDITIONS	ENBREL	14.0%
ANTIHYPERLIPIDEMIC	PRALUENT	13.5%	INFLAMMATORY CONDITIONS	HUMIRA	15.5%
ANTIHYPERLIPIDEMIC	REPATHA	14.0%	INFLAMMATORY CONDITIONS	ILUMYA	14.1%
ANTI-INFECTIVE	ARIKAYCE	13.0%	INFLAMMATORY CONDITIONS	KEVZARA	9.9%
ANTI-INFECTIVE	DARAPRIM	12.5%	INFLAMMATORY CONDITIONS	KINERET	13.2%
CARDIOVASCULAR	NORTHERA	14.0%	INFLAMMATORY CONDITIONS	OLUMIANT	12.5%
CNS AGENTS	AUSTEDO	12.5%	INFLAMMATORY CONDITIONS	ORENCIA	14.2%
CNS AGENTS	HETLIOZ	14.0%	INFLAMMATORY CONDITIONS	OTEZLA	13.5%
CNS AGENTS	INGREZZA	13.0%	INFLAMMATORY CONDITIONS	RIDAURA	14.1%
CNS AGENTS	RILUTEK	13.5%	INFLAMMATORY CONDITIONS	SILIQ	11.4%
CNS AGENTS	RILUZOLE	13.5%	INFLAMMATORY CONDITIONS	SIMPONI	14.1%
CNS AGENTS	SABRIL	16.1%	INFLAMMATORY CONDITIONS	STELARA	12.5%
CNS AGENTS	TETRABENAZINE	38.2%	INFLAMMATORY CONDITIONS	TALTZ	11.4%
CNS AGENTS	TIGLUTIK	6.0%	INFLAMMATORY CONDITIONS	TREMFYA	14.1%
CNS AGENTS	VIGABATRIN	17.6%	INFLAMMATORY CONDITIONS	XELJANZ	13.5%
CNS AGENTS	VIGADRONE	16.6%	INFLAMMATORY CONDITIONS	XELJANZ XR	13.5%
CNS AGENTS	XENAZINE	12.5%	IRON OVERLOAD	EXJADE	12.1%
CNS AGENTS	XYREM	6.3%	IRON OVERLOAD	FERRIPROX	12.5%
CYSTIC FIBROSIS	BETHKIS	11.4%	IRON OVERLOAD	JADENU	13.5%
CYSTIC FIBROSIS	CAYSTON	14.5%	LIVER DISEASE	OCALIVA	15.0%
CYSTIC FIBROSIS	KALYDECO	13.5%	MONOCLONAL ANTIBODY MISCELLANEOUS	BENLYSTA	13.5%
CYSTIC FIBROSIS	KITABIS PAK	12.5%	MULTIPLE SCLEROSIS	AMPYRA	11.7%

CYSTIC FIBROSIS	ORKAMBI	13.5%	MULTIPLE SCLEROSIS	AUBAGIO	12.5%
CYSTIC FIBROSIS	PULMOZYME	15.0%	MULTIPLE SCLEROSIS	AVONEX	13.5%
CYSTIC FIBROSIS	SYMDEKO	13.5%	MULTIPLE SCLEROSIS	BETASERON	14.1%
CYSTIC FIBROSIS	TOBI	13.8%	MULTIPLE SCLEROSIS	COPAXONE	14.7%
CYSTIC FIBROSIS	TOBI PODHALER	13.8%	MULTIPLE SCLEROSIS	DALFAMPRIDIN	38.2%
CYSTIC FIBROSIS	TOBRAMYCIN	37.2%	MULTIPLE SCLEROSIS	EXTAVIA	13.5%
ENDOCRINE	BUPHENYL	13.5%	MULTIPLE SCLEROSIS	GILENYA	14.0%
ENDOCRINE	CARBAGLU	7.3%	MULTIPLE SCLEROSIS	GLATIRAMER	69.7%
ENDOCRINE	CHENODAL	9.4%	MULTIPLE SCLEROSIS	GLATOPA	33.1%
ENDOCRINE	CUPRIMINE	13.5%	MULTIPLE SCLEROSIS	PLEGRIDY	13.5%
ENDOCRINE	CYSTADANE	10.4%	MULTIPLE SCLEROSIS	REBIF	14.0%
ENDOCRINE	CYSTARAN	13.0%	MULTIPLE SCLEROSIS	REBIF REBIDOSE	14.0%
ENDOCRINE	DEPEN TITRATABS	14.0%	MULTIPLE SCLEROSIS	TECFIDERA	13.5%
ENDOCRINE	EGRIFTA	13.5%	MULTIPLE SCLEROSIS	ZINBRYTA	12.5%
ENDOCRINE	FIRMAGON	13.5%	NEUTROPENIA	FULPHILA	13.8%
ENDOCRINE	GATTEX	14.8%	NEUTROPENIA	GRANIX	13.8%
ENDOCRINE	H.P. ACTHAR	13.5%	NEUTROPENIA	LEUKINE	13.8%
ENDOCRINE	JYNARQUE	12.5%	NEUTROPENIA	NEULASTA	13.8%
ENDOCRINE	KEVEYIS	13.0%	NEUTROPENIA	NEUPOGEN	13.8%
ENDOCRINE	KORLYM	11.4%	NEUTROPENIA	NIVESTYM	13.8%
ENDOCRINE	KUVAN	12.7%	NEUTROPENIA	UDENYCA	13.8%
ENDOCRINE	MYALEPT	7.3%	NEUTROPENIA	ZARXIO	13.8%
ENDOCRINE	NATPARA	13.2%	ONCOLOGY - INJECTABLE	INTRON A	13.5%
ENDOCRINE	NITYR	11.9%	ONCOLOGY - INJECTABLE	SYLATRON	13.5%
ENDOCRINE	OCTREOTIDE ACETATE	46.4%	ONCOLOGY - INJECTABLE	SYNRIBO	11.4%
ENDOCRINE	PROCYSBI	7.3%	ONCOLOGY - ORAL	ABIRATERONE	33.1%
ENDOCRINE	RAVICTI	12.5%	ONCOLOGY - ORAL	AFINITOR	13.5%
ENDOCRINE	SAMSCA	13.5%	ONCOLOGY - ORAL	AFINITOR DISPERZ	13.5%
ENDOCRINE	SANDOSTATIN	33.1%	ONCOLOGY - ORAL	ALECENSA	14.1%
ENDOCRINE	SIGNIFOR	7.3%	ONCOLOGY - ORAL	ALKERAN	15.4%
ENDOCRINE	SODIUM PHENYLBUTYRATE	33.1%	ONCOLOGY - ORAL	ALUNBRIG	11.9%
ENDOCRINE	SOMATULINE DEPOT	13.5%	ONCOLOGY - ORAL	BEXAROTENE	33.5%
ENDOCRINE	SOMAVERT	10.6%	ONCOLOGY - ORAL	BOSULIF	13.5%
ENDOCRINE	SYPRINE	13.5%	ONCOLOGY - ORAL	BRAFTOVI	12.5%
ENDOCRINE	THIOLA	11.4%	ONCOLOGY - ORAL	CABOMETYX	12.5%

ENDOCRINE	TRIENTINE	47.2%	ONCOLOGY - ORAL	CALQUENCE	12.5%
ENDOCRINE	XERMELO	13.0%	ONCOLOGY - ORAL	CAPECITABINE	33.1%
ENDOCRINE	XURIDEN	12.5%	ONCOLOGY - ORAL	CAPRELSA	9.4%
ENZYME DEFICIENCY	CHOLBAM	4.2%	ONCOLOGY - ORAL	COMETRIQ	10.9%
ENZYME DEFICIENCY	CYSTAGON	10.9%	ONCOLOGY - ORAL	COPIKTRA	12.5%
ENZYME DEFICIENCY	GALAFOLD	14.0%	ONCOLOGY - ORAL	COTELLIC	12.5%
ENZYME DEFICIENCY	MIGLUSTAT	7.3%	ONCOLOGY - ORAL	DAURISMO	12.5%
ENZYME DEFICIENCY	ORFADIN	2.2%	ONCOLOGY - ORAL	ERIVEDGE	12.5%
ENZYME DEFICIENCY	PALYNZIQ	11.4%	ONCOLOGY - ORAL	ERLEADA	13.5%
ENZYME DEFICIENCY	STRENSIQ	11.3%	ONCOLOGY - ORAL	FARYDAK	11.4%
ENZYME DEFICIENCY	SUCRAID	12.2%	ONCOLOGY - ORAL	GILOTRIF	7.3%
ENZYME DEFICIENCY	TEGSEDI	7.3%	ONCOLOGY - ORAL	GLEEVEC	15.4%
ENZYME DEFICIENCY	ZAVESCA	7.3%	ONCOLOGY - ORAL	HYCAMTIN	14.8%
GAUCHERS DISEASE	CERDELGA	13.5%	ONCOLOGY - ORAL	IBRANCE	13.0%
GROWTH HORMONE DEFICIENCY	GENOTROPIN	14.1%	ONCOLOGY - ORAL	ICLUSIG	12.7%
GROWTH HORMONE DEFICIENCY	HUMATROPE	14.7%	ONCOLOGY - ORAL	IDHIFA	14.5%
GROWTH HORMONE DEFICIENCY	INCRELEX	13.5%	ONCOLOGY - ORAL	IMATINIB MESYLATE	65.2%
GROWTH HORMONE DEFICIENCY	NORDITROPIN	16.0%	ONCOLOGY - ORAL	IMBRUVICA	12.5%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	14.2%	ONCOLOGY - ORAL	INLYTA	13.5%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ NUSPIN	14.2%	ONCOLOGY - ORAL	IRESSA	12.5%
GROWTH HORMONE DEFICIENCY	OMNITROPE	13.9%	ONCOLOGY - ORAL	JAKAFI	12.5%
GROWTH HORMONE DEFICIENCY	SAIZEN	17.5%	ONCOLOGY - ORAL	KISQALI	14.5%
GROWTH HORMONE DEFICIENCY	SEROSTIM	13.5%	ONCOLOGY - ORAL	KISQALI FEMARA	14.5%
GROWTH HORMONE DEFICIENCY	ZOMACTON	14.7%	ONCOLOGY - ORAL	LENVIMA	13.5%
GROWTH HORMONE DEFICIENCY	ZORBTIVE	13.0%	ONCOLOGY - ORAL	LONSURF	12.5%
HEMATOLOGIC	BERINERT	12.5%	ONCOLOGY - ORAL	LORBRENA	12.5%
HEMATOLOGIC	CINRYZE	12.5%	ONCOLOGY - ORAL	LYNPARZA	12.2%
HEMATOLOGIC	DOPTELET	13.5%	ONCOLOGY - ORAL	MATULANE	13.0%

HEMATOLOGIC	FIRAZYR	13.5%	ONCOLOGY - ORAL	MEKINIST	11.4%
HEMATOLOGIC	HAEGARDA	12.5%	ONCOLOGY - ORAL	MEKTOVI	12.5%
HEMATOLOGIC	MOZOBIL	13.5%	ONCOLOGY - ORAL	MELPHALAN	33.1%
HEMATOLOGIC	MULPLETA	13.5%	ONCOLOGY - ORAL	MESNEX	14.0%
HEMATOLOGIC	PROMACTA	13.5%	ONCOLOGY - ORAL	NERLYNX	14.3%
HEMATOLOGIC	RUCONEST	13.2%	ONCOLOGY - ORAL	NEXAVAR	12.5%
HEMATOLOGIC	TAKHZYRO	12.5%	ONCOLOGY - ORAL	NINLARO	13.5%
HEMATOLOGIC	TAVALISSE	13.5%	ONCOLOGY - ORAL	ODOMZO	13.8%
HEMOPHILIA - INFUSED	ADVATE	41.0%	ONCOLOGY - ORAL	POMALYST	13.0%
HEMOPHILIA - INFUSED	ADYNOVATE	32.0%	ONCOLOGY - ORAL	REVLIMID	12.2%
HEMOPHILIA - INFUSED	AFSTYLA	34.0%	ONCOLOGY - ORAL	RUBRACA	12.5%
HEMOPHILIA - INFUSED	ALPHANATE/VON WILLEBRAND	39.5%	ONCOLOGY - ORAL	RYDAPT	15.4%
HEMOPHILIA - INFUSED	ALPHANINE SD	44.9%	ONCOLOGY - ORAL	SPRYCEL	15.4%
HEMOPHILIA - INFUSED	ALPROLIX	13.5%	ONCOLOGY - ORAL	STIVARGA	11.9%
HEMOPHILIA - INFUSED	BEBULIN	20.7%	ONCOLOGY - ORAL	SUTENT	13.7%
HEMOPHILIA - INFUSED	BENEFIX	13.5%	ONCOLOGY - ORAL	TAFINLAR	13.5%
HEMOPHILIA - INFUSED	COAGADEX	30.0%	ONCOLOGY - ORAL	TAGRISSO	13.5%
HEMOPHILIA - INFUSED	CORIFACT	27.9%	ONCOLOGY - ORAL	TALZENNA	12.5%
HEMOPHILIA - INFUSED	ELOCTATE	27.9%	ONCOLOGY - ORAL	TARCEVA	14.3%
HEMOPHILIA - INFUSED	FEIBA	31.1%	ONCOLOGY - ORAL	TARGRETIN	14.0%
HEMOPHILIA - INFUSED	HELIXATE FS	40.2%	ONCOLOGY - ORAL	TASIGNA	13.5%
HEMOPHILIA - INFUSED	HEMOFIL M	44.4%	ONCOLOGY - ORAL	TEMODAR	14.8%
HEMOPHILIA - INFUSED	HUMATE-P	37.1%	ONCOLOGY - ORAL	TEMOZOLOMIDE	51.6%
HEMOPHILIA - INFUSED	IDELVION	13.5%	ONCOLOGY - ORAL	THALOMID	14.8%
HEMOPHILIA - INFUSED	IXINITY	13.5%	ONCOLOGY - ORAL	TIBSOVO	13.5%
HEMOPHILIA - INFUSED	JIVI	22.8%	ONCOLOGY - ORAL	TRETINOIN	44.2%
HEMOPHILIA - INFUSED	KOATE	42.3%	ONCOLOGY - ORAL	TYKERB	14.8%
HEMOPHILIA - INFUSED	KOATE-DVI	42.3%	ONCOLOGY - ORAL	VENCLEXTA	12.5%
HEMOPHILIA - INFUSED	KOGENATE FS	44.3%	ONCOLOGY - ORAL	VERZENIO	13.0%
HEMOPHILIA - INFUSED	KOVALTRY	35.1%	ONCOLOGY - ORAL	VITRAKVI	14.5%
HEMOPHILIA - INFUSED	MONOCLATE-P	33.7%	ONCOLOGY - ORAL	VIZIMPRO	12.5%
HEMOPHILIA - INFUSED	MONONINE	31.4%	ONCOLOGY - ORAL	VOTRIENT	13.5%
HEMOPHILIA - INFUSED	NOVOEIGHT	41.8%	ONCOLOGY - ORAL	XALKORI	11.9%
HEMOPHILIA - INFUSED	NOVOSEVEN RT	33.7%	ONCOLOGY - ORAL	XELODA	15.4%
HEMOPHILIA - INFUSED	NUWIQ	36.1%	ONCOLOGY - ORAL	XOSPATA	14.5%

HEMOPHILIA - INFUSED	PROFILNINE	30.0%	ONCOLOGY - ORAL	XTANDI	13.5%
HEMOPHILIA - INFUSED	REBINYN	17.6%	ONCOLOGY - ORAL	YONSA	13.5%
HEMOPHILIA - INFUSED	RECOMBINATE	40.2%	ONCOLOGY - ORAL	ZEJULA	13.5%
HEMOPHILIA - INFUSED	RIXUBIS	13.7%	ONCOLOGY - ORAL	ZELBORAF	13.0%
HEMOPHILIA - INFUSED	TRETTEN	12.5%	ONCOLOGY - ORAL	ZOLINZA	14.8%
HEMOPHILIA - INFUSED	VONVENDI	11.9%	ONCOLOGY - ORAL	ZYDELIG	13.5%
HEMOPHILIA - INFUSED	WILATE	36.1%	ONCOLOGY - ORAL	ZYKADIA	13.0%
HEMOPHILIA - INFUSED	XYNTHA	38.4%	ONCOLOGY - ORAL	ZYTIGA	13.5%
HEMOPHILIA - INJECTABLE	HEMLIBRA	12.5%	ONCOLOGY - TOPICAL	TARGRETIN	14.0%
HEPATITIS B	ADEFOVIR DIPIVOXIL	33.1%	ONCOLOGY - TOPICAL	VALCHLOR	7.8%
HEPATITIS B	BARACLUDE	13.5%	OPHTHALMIC	OXERVATE	12.5%
HEPATITIS B	ENTECAVIR	56.7%	OSTEOPOROSIS	FORTEO	13.5%
HEPATITIS B	EPIVIR HBV	33.1%	OSTEOPOROSIS	TYMLOS	13.3%
HEPATITIS B	HEPSERA	13.5%	PARKINSONS DISEASE	APOKYN	11.5%
HEPATITIS B	LAMIVUDINE HBV	33.1%	PULMONARY DISEASE	ESBRIET	13.5%
HEPATITIS B	VEMLIDY	13.3%	PULMONARY DISEASE	OFEV	12.5%
HEPATITIS C	DAKLINZA	13.5%	PULMONARY HYPERTENSION	ADCIRCA	13.5%
HEPATITIS C	EPCLUSA	13.5%	PULMONARY HYPERTENSION	ADEMPAS	13.5%
HEPATITIS C	HARVONI	15.0%	PULMONARY HYPERTENSION	LETAIRIS	12.7%
HEPATITIS C	LEDIPASVIR/SOFOSBUVIR	13.5%	PULMONARY HYPERTENSION	OPSUMIT	12.7%
HEPATITIS C	MAVYRET	14.0%	PULMONARY HYPERTENSION	ORENITRAM	13.5%
HEPATITIS C	OLYSIO	14.3%	PULMONARY HYPERTENSION	REVATIO	13.3%
HEPATITIS C	PEGASYS	16.4%	PULMONARY HYPERTENSION	TADALAFIL	13.5%
HEPATITIS C	PEGINTRON	17.5%	PULMONARY HYPERTENSION	TRACLEER	13.5%
HEPATITIS C	SOFOSBUVIR/VELPATASVIR	13.5%	PULMONARY HYPERTENSION	TYVASO	13.0%
HEPATITIS C	SOVALDI	14.0%	PULMONARY HYPERTENSION	UPTRAVI	14.5%
HEPATITIS C	TECHNIVIE	13.5%	PULMONARY HYPERTENSION	VENTAVIS*	13.0%
HEPATITIS C	VIEKIRA PAK	13.5%	TRANSPLANT	ASTAGRAF XL	12.5%
HEPATITIS C	VIEKIRA XR	13.5%	TRANSPLANT	CELLCEPT	13.4%

HEPATITIS C	VOSEVI	14.0%	TRANSPLANT	CYCLOSPORINE	51.8%
HEPATITIS C	ZEPATIER	13.9%	TRANSPLANT	CYCLOSPORINE MODIFIED	51.8%
IMMUNE MODULATOR	ACTIMMUNE	14.3%	TRANSPLANT	ENVARSUS XR	13.5%
IMMUNE MODULATOR	ARCALYST	15.0%	TRANSPLANT	GENGRAF	64.0%
INFERTILITY	BRAVELLE	13.2%	TRANSPLANT	MYCOPHENOLATE MOFETIL	93.4%
INFERTILITY	CETROTIDE	14.3%	TRANSPLANT	MYCOPHENOLIC ACID	33.1%
INFERTILITY	CHORIONIC GONADOTROPIN	22.8%	TRANSPLANT	MYCOPHENOLIC ACID DR	33.1%
INFERTILITY	FOLLISTIM AQ	13.2%	TRANSPLANT	MYFORTIC	14.3%
INFERTILITY	GANIRELIX ACETATE	10.0%	TRANSPLANT	NEORAL	23.9%
INFERTILITY	GONAL-F	22.9%	TRANSPLANT	PROGRAF	14.1%
INFERTILITY	GONAL-F RFF	22.8%	TRANSPLANT	RAPAMUNE	14.3%
INFERTILITY	MENOPUR	10.0%	TRANSPLANT	SANDIMMUNE	27.1%
INFERTILITY	NOVAREL	15.0%	TRANSPLANT	SIROLIMUS	33.1%
INFERTILITY	OVIDREL	14.3%	TRANSPLANT	TACROLIMUS	79.1%
INFERTILITY	PREGNYL	14.5%	TRANSPLANT	ZORTRESS	13.5%

*Includes Nebulizer

THE AMENDED NON-FINANCIAL TERMS ARE AS FOLLOWS:

The Administrative Services Agreement is amended on January 1, 2020 as noted below.

Effective January 1, 2020, the Maternity Program is in full force and effect as described in Section 4 as follows:

Section 4.24 Maternity Program. United, through United's affiliate, will provide a maternity program to eligible Participants. This is a maternity wellness program designed to provide Participants with personal guidance and support. This program may include access to: dedicated maternity nurses experienced in high-risk pregnancies and premature births; pregnancy consultations; support for special health care needs; customized maternity education materials and integration with other applicable care management programs United provides to Customer as set forth in this Agreement.

This language replaces and supersedes any references in the Agreement to the Healthy Pregnancy Program, including related fees.

Effective January 1, 2020, the Healthy Weight Program no longer applies. If included in the Agreement, any references to the Healthy Weight Program are hereby removed.

Effective January 1, 2020, the UnitedHealth Allies Discount Program no longer applies. If included in the Agreement, any reference to the UnitedHealth Allies Discount Program are hereby removed.

Effective January 1, 2020, NurseLine and Care24 will transition to 24/7 access to care and Employee Assistance Program (EAP).

Effective January 1, 2020, Section 4.16 for Pharmacy Benefit Services is replaced with the following:

Claims Processing. United will process the claims received from a Network Pharmacy in accordance with the Summary Plan Description, as well as the pricing and other terms of the Network Pharmacy's participation agreement. On mail order, retail and specialty pharmacy services, United will retain the difference between what United reimburses the Network Pharmacy and Customer payment for a Prescription Drug product or service. United maintains systems for processing pharmacy claims and may receive access fees as compensation for services United provides to Network Pharmacies.

Effective January 1, 2020, any reference to recovery services in the Agreement, each as applicable, are replaced in their entirety as follows:

Section 4.7 Claim Recovery Services. United will provide recovery services for Overpayments and other Plan recovery opportunities as described herein. United will not be responsible for reimbursement of any unrecovered Overpayment nor attorneys' fees and costs related to litigation or arbitration associated with recoveries except to the extent an arbitrator, arbitration panel, or court of competent jurisdiction determines that the Overpayment was due to United's gross negligence or willful misconduct. Under no circumstances will United be responsible for reimbursement of unrecovered Overpayments resulting from a third party's fraud.

Overpayments. United utilizes generally-accepted auditing protocols to identify Overpayments. United will attempt to recover Overpayments by employing appropriate outreach to Participants and/or providers to request reimbursement.

Fraud, Waste, and Abuse Management. United will provide services related to detection, and recovery of wasteful, abusive, and/or fraudulent claims. United's Fraud, Waste, and Abuse Management processes will be based upon United's proprietary and confidential procedures, modes of analysis, and investigations. United will use these procedures and standards in delivering Fraud, Waste, and Abuse Management services to Customer and to United's other customers. Services include all work to identify recovery opportunities, research, data analysis, investigation, and initiation of all Recovery Processes set forth below. United does not guarantee or warranty any particular level of

prevention, detection, or recovery. United agrees to perform Fraud, Waste, and Abuse Management services pursuant to the industry standards for such services.

Credit Balance Recovery. United utilizes on-site resources to perform hospital and/or facility audits to review, validate, and recover credit balances (dollars) existing on patient accounts to identify any recoverable amounts.

Hospital Bill Audit. United utilizes on-site resources (registered/licensed nurses and/or certified coders) to perform in-depth reviews of hospital bills. Auditors will conduct line by line comparisons of itemized bills to the medical records to ensure billing accuracy and identify any recoverable amounts.

Subrogation. United will provide services to recover Plan benefits that were paid and are recoverable by the Plan because payment was or should have been made by a third party for the same medical expense (other than in connection with coordination of benefits, Medicare, or other Overpayments). This is referred to as "Third Party Liability Recovery" or "Subrogation". Customer will not engage any entity except United to provide the services described in this Section without United's prior approval.

Advanced Analytic Recovery Services. United will use large scale analytics, information, and analysis to identify post-adjudication claims for additional recovery opportunities.

Focused Claim Review. Board certified same-specialty physicians will audit claims and records of high-cost procedures. These reviews verify coding and billing accuracy before a claim is adjudicated. Claims for which billing and/or coding errors are identified will be adjusted before payment is issued.

Recovery Process – Non-Class Action Recoveries. Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery opportunity, including but not limited to, whether or not to seek recovery, what steps to take if United decides to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where United pursues recovery through litigation or arbitration, Customer, on behalf of itself and on behalf of its Plan(s), will be deemed to have granted United an assignment of all ownership, title and legal rights and interests in and to any and all claims that are the subject matter of the litigation or arbitration.

Customer acknowledges that use of United's standards and procedures may not result in full or partial recovery for any particular claim or for any particular Customer. United will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical, as determined in United's discretion. While United may initiate litigation or arbitration to facilitate a recovery, United has no obligation to do so. If United initiates litigation or arbitration, Customer will cooperate with United in the litigation or arbitration.

If this Agreement terminates, in whole or in part, United can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section 4.7.

Recovery Process – Class Action Recoveries. Where a class action purports to affect Customer's (or the Plan(s) it sponsors or administers) right to and interest in any Overpayment, United has the right to determine whether to seek recovery of the Overpayment on the Customer's (or the Plan(s) it sponsors or administers) behalf through litigation, arbitration, or settlement. If United elects to seek recovery of such an Overpayment that is at issue in a class action, United will provide written notice to Customer of its intention. If Customer does not want United to seek recovery of the Overpayment, Customer shall notify United in writing within thirty (30) days of receiving notice from United. If Customer does not so notify United, Customer, on behalf of itself and on behalf of the Plan(s) it sponsors and administers, assigns to United all ownership, title and legal rights and interests in and to any and all Overpayments that are the subject matter of the class action. In such cases, Customer will cooperate with United in any resulting litigation or arbitration that United may file to pursue the Overpayments.

If Customer provides United with written notice that it does not want United to seek recovery of an Overpayment related to a class action (whether putative or certified) then, pursuant to its standard procedures, United will provide Customer with related Overpayment claims information, at Customer's request. Customer is then solely responsible for determining whether it (or the Plan(s) it sponsors or administers) will participate in the class action (whether putative or certified), participate in any class action settlement, pursue recovery of the relevant Overpayment outside of the class action, or take any other action with respect to any cause of action the Customer (or the Plan(s) it sponsors or administers) might have.

If this Agreement terminates, in whole or in part, United can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section 4.7.

Offsetting Process. Overpayment recoveries may occur by offsetting the Overpayment against future payments to the provider made by United. In effectuating Overpayment recoveries through offset, United will follow its established Overpayment recovery rules which include, among other things, prioritizing Overpayment credits based on: (1) the age of the Overpayment for electronic payments and (2) the funding type and the age of the Overpayment for check payments. United may recover the Overpayment by offsetting, in whole or in part, against: (1) future benefits that are payable under the Plan in connection with services provided to any Participants; or (2) future benefits that are payable in connection with services provided by a Network Provider to individuals covered under other self-insured or fully-insured plans for which United processes payments (a "Cross Plan Offset"). In addition to permitting United to recover Overpayments on behalf of the Plan from benefits payable under other plans, United will enable other plans (including plans fully insured by United) to recover their Overpayments from benefits payable under the Plan through Cross Plan Offsets. Customer understands and agrees that in doing so, the Plan is participating in a cooperative overpayment recovery effort with other plans for which United acts as the claims administrator. Reallocations pursuant to this process do not impact the decision as to whether or not a benefit is payable under the Plan. Customer represents and warrants that the Plan SPD contains United's approved template language authorizing Cross Plan Offsets. Customer hereby directs United not to use the Cross Plan Offset method of recovering Overpayments for out-of-network providers. Customer acknowledges that due to this direction, Overpayment recoveries may take longer to process and that the overall recovery amount may be less. United is not liable to Customer for any Overpayments not recovered that could have been recovered through the use of the Cross Plan Offset process for Out-of-Network providers.

In United's application of Overpayment recovery through offset, timing differences may arise in the processing of claims payments, disbursement of provider checks, and the recovery of Overpayments. As a result, the Plan may in some instances receive the benefit of an Overpayment recovery before United actually receives the funds from the provider. Conversely, United may receive the funds before the Plan receives the credit for the Overpayment. It is hereby understood that the Parties may retain any interest that accrues as a result of these timing differences. Details associated with Overpayment recoveries made on behalf of the Plan through offset will be identified in the monthly reconciliation report provided to the Customer's Plan. The monthly reconciliation report will contain information relating only to Customer's Plan and will not contain information relating to other plans for which United acts as the claims administrator.

Recovery Fees. Customer will be charged a fee for the services described in this Section 4.7. That fee is set forth in Exhibit A-Fees.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is made in connection with the Administrative Services Agreement (Agreement) between UnitedHealthcare Insurance Company identified as Contract No. 701043 on behalf of itself and its Affiliates Business Associate and Adams County Government's group health plan (Covered Entity) (each a "Party" and collectively the "Parties") and is effective August 1, 2016 (Effective Date). This BAA replaces the terms of any business associate BAA between the parties

The Parties hereby agree as follows:

RECITALS:

WHEREAS, Covered Entity is subject to federal privacy rules promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the American Recovery and Reinvestment Act of 2009/HITECH Act (P.L. 11-005); and

WHEREAS, Business Associate provides services for Covered Entity that may involve access to, use, or disclosure of Protected Health Information ("PHI") ; and

WHEREAS, Covered Entity and Business Associate are committed to complying with the Privacy and Security Regulations and desire to set forth the rights and responsibilities of the parties with respect to Protected Health Information;

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the sufficiency of which is hereby acknowledged by the parties, the parties agree as follows:

1. DEFINITIONS

1.1 Capitalized terms used but not otherwise defined in this BAA have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA".

1.3 "ARRA" shall mean the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and any and all references in this BAA to sections of ARRA shall be deemed to include all associated existing and future implementing regulations, when and as each is effective.

1.4 "Breach" shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. § 164.402.

1.5 "Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of ARRA and/or its implementing regulations, as applicable; provided that, in any case for which that date occurs prior to the Effective Date of this BAA, the Compliance Date shall mean the Effective Date.

1.6 "Electronic Protected Health Information" (ePHI) shall mean PHI as defined in Section 1.7 that is transmitted or maintained in electronic media.

1.7 "Individual" shall have the same meaning as the term "Individual" in 45 § C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R § 164.502(g).

1.8 "PHI" shall mean Protected Health Information, as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, Covered Entity by Business Associate pursuant to the performance of the Services.

1.9 "Privacy Rule" shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. §§ 160 and 164 (Subparts A & E).

1.10 "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

1.11 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

1.13 "Security Rule" shall mean the federal security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. §§ 160 and 164 (Subparts A & C).

1.14 "Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to Covered Entity under the Agreement, including those set forth in this BAA in Sections 4.3 through 4.7, as amended by written agreement of the Parties from time to time.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE

With regard to its use and/or disclosure of PHI, Business Associate agrees to:

2.1 Use and/or disclose PHI only as necessary to provide the Services, as permitted or required by this BAA and in compliance with each applicable requirement of 45 C.F.R. 164.504(e) or as otherwise Required by Law; provided that, to the extent Business Associate is to carry out Covered Entity's

obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

2.2 Develop, implement, maintain and use appropriate administrative, physical and technical safeguards to (i) prevent use or disclosure of PHI other than as permitted or required by this BAA, or as otherwise required by law; (ii) reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity; and (iii) as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.

2.3 Without unreasonable delay, report to Covered Entity: (i) any use or disclosure of PHI, of which it becomes aware, that is not provided for by this BAA and/or the Agreement; and/or (ii) any Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. § 164.314(a)(2)(i)(C).

2.4 With respect to any use or disclosure of Unsecured PHI not permitted by the Privacy Rule that is caused solely by Business Associate's failure to comply with one or more of its obligations under this BAA, Covered Entity hereby delegates to Business Associate the responsibility for determining when any such incident is a Breach. In the event of a Breach, Business Associate shall (i) provide Covered Entity with written notification, and (ii) provide all legally required notifications to Individuals, HHS and/or the media, on behalf of Covered Entity. Business Associate shall provide these notifications in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. §§ 160 & 164 subparts A, D & E as of their respective Compliance Dates, and shall pay for the reasonable and actual costs associated with such notifications. In the event of a Breach, without unreasonable delay, and in any event no later than sixty (60) calendar days after Discovery, Business Associate shall provide Covered Entity with written notification that includes a description of the Breach, a list of Individuals and a copy of the template notification letter to be sent to Individuals.

2.5 Require all of its subcontractors and agents that create, receive, maintain, or transmit PHI on behalf of Business Associate to agree, in writing, to the same restrictions and conditions on the use and/or disclosure of PHI that apply to Business Associate; including but not limited to the extent that Business Associate with respect to that PHI.

2.6 Make available its internal practices, books, and records relating to the use and disclosure of PHI to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule.

2.7 After receiving a written request from Covered Entity or an Individual, make available to the Covered Entity, or at the direction of the Covered Entity,

directly to an Individual, an accounting of disclosures of PHI about the Individual, in accordance with 45 C.F.R. § 164.528.

2.8 Notwithstanding Section 2.7, in the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an Individual, then Business Associate shall, when and as directed by Covered Entity or when requested by an Individual, make an accounting of disclosures of PHI directly to an Individual within thirty (30) days after receiving a written request, in accordance with the requirements for accounting for disclosures made through an Electronic Health Record in 42 U.S.C. § 17935(c) as of its Compliance Date.

2.9 Provide accessafter receiving a written request from Covered Entity or an Individual, to PHI in a Designated Record Set about an Individual, to the Covered Entity, or at the direction of the Covered Entity, directly to an Individual, in accordance with the requirements of 45 C.F.R. § 164.524.

2.10 Notwithstanding Section 2.9, in the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an Individual, then Business Associate shall provide an electronic copy of the PHI, directly to an Individual or a third party designated by the Individual, all in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date.

2.11 To the extent that the PHI in Business Associate's possession constitutes a Designated Record Set, make available, within thirty (30) days after a written request by Covered Entity or an Individual, PHI for amendment and incorporate any amendments to the PHI, as directed by Covered Entity or an Individual, all in accordance with 45 C.F.R. § 164.526.

2.12 Request, use and/or disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure; provided, that Business Associate shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date.

2.13 Accommodate reasonable requests by Individuals for confidential communications in accordance with 45 C.F.R. 164.522(b) of the Privacy Rule.
2.14 Not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

2.15 Not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

2.16 Not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

2.17 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of this BAA.

3. RESPONSIBILITIES OF COVERED ENTITY

In addition to any other obligations set forth in th Agreement, including this BAA, Covered Entity:

3.1 Shall provide to Business Associate only the minimum PHI necessary to accomplish the Services

3.2 Shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

3.3 Shall notify Business Associate of any changes in, or revocation of, permission by Individuals to use or disclose Protected Health Information, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

3.4 Shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

3.5 Agrees and understands that the Covered Entity is independently responsible for the security of all PHI in its possession (electronic or otherwise), including all PHI that it receives from outside sources, including the Business Associate.

3.6 In the event Covered Entity takes action as described in this Section, Business Associate shall decide which restrictions or limitations it will administer. In addition, if those limitations or revisions materially increase Business Associate's cost of providing Services under the Agreement, including this BAA, Covered Entity shall reimburse Business Associate for such increase in cost.

4. OTHER PERMITTED USES AND DISCLOSURES OF PHI

Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or required by this BAA or the Agreement, Business Associate may:

4.1 Make any and all uses and disclosures of PHI necessary to provide the Services to Covered Entity.

4.2 Use and disclose to subcontractors and agents the PHI in its possession for its proper management and administration or to carry out the legal responsibilities of Business Associate, provided that any third party to which Business Associates discloses PHI for those purposes provides written assurances in advance that: (i) the information will be held confidentially and used or further disclosed only as Required by Law; (ii) the information will be used only for the purpose for which it was disclosed to the third party; and (iii) the third party promptly will notify

Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

4.3 De-identify any and all PHI obtained by Business Associate under this BAA, which De-identified information does not constitute PHI, is not subject to this BAA and may be used and disclosed on Business Associate's own behalf, all in accordance with the De-identification requirements of the Privacy Rule.

4.4 Provide Data Aggregation services relating to the Health Care Operations of the Covered Entity, including through subcontractors and agents, in accordance with the Privacy Rule.

4.5 Identify Research projects conducted by Business Associate, its Affiliates or third parties for which PHI may be relevant; obtain on behalf of Covered Entity documentation of individual authorizations or an Institutional Review Board or privacy board waiver that meets the requirements of 45 C.F.R. § 164.512(i)(1) (each an ""Authorization" or "Waiver") related to such projects; provide Covered Entity with copies of such Authorizations or Waivers, subject to confidentiality obligations owed to the sponsor of the study ("Required Documentation"); and disclose PHI for such Research provided that Business Associate does not receive Covered Entity's disapproval in writing within ten (10) days of Covered Entity's receipt of Required Documentation.

4.6 Make PHI available for reviews preparatory to Research and obtain and maintain written representations in accord with 45 C.F.R. 164.512(i)(1)(ii) that the requested PHI is sought solely as necessary to prepare a Research protocol or for similar purposes preparatory to Research, that the PHI is necessary for the Research, and that no PHI will be removed from the location in which it is being held on behalf of the Covered Entity in the course of the review.

4.7 Use the PHI to create a Limited Data Set ("LDS") in compliance with 45 C.F.R. 164.514(e).

4.8 Use and disclose the LDS referenced in Section 4.7 solely for Research, Health Care Operations, or Public Health purposes provided that Business Associate shall: (1) not use or further disclose the information other than as permitted by this Section 4.8 or as otherwise Required by Law; (2) use appropriate safeguards to prevent use or disclosure of the information other than as provided for by this Section 4.8; (3) report to Covered Entity any use or disclosure of the information not provided for by this Section 4.8 of which Business Associate becomes aware; (iv) ensure that any agents or subcontractors to whom Business Associate provides the LDS agree to the same restrictions and conditions that apply to Business Associate with respect to such information; and (v) not identify the information or contact the individuals.

5. TERM, TERMINATION, COOPERATION, AND INDEMNIFICATION

5.1 Term. The Term of this BAA shall be effective as of the Effective Date, and shall terminate upon the final expiration of the contract or business arrangement unless earlier terminated in accordance with Section 5.2 of this BAA.

5.2 Termination. If either Party knows of a pattern of activity or practice of the other Party that constitutes a material breach or violation of this BAA then the non-breaching Party shall provide written notice of the breach or violation to the other Party that specifies the nature of the breach or violation. The breaching Party must cure the breach or end the violation on or before sixty (30) days after receipt of the written notice. In the absence of a cure reasonably satisfactory to the non-breaching Party within the specified time frame, or in the event the breach is reasonably incapable of cure, then the non-breaching Party may do the following:

(1) If feasible, terminate the Agreement, including this BAA; or

(2) If termination of the Agreement is infeasible, report the issue to HHS.

5.3 Effect of Termination or Expiration. Within sixty (60) days after the termination or expiration of the contract and/or this BAA, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in possession of Business Associate's agents or subcontractors. If Business Associate determines that return or destruction of the PHI is not feasible, Business Associate may retain the PHI subject to this Section 5.3. Under any circumstances, Business Associate shall extend any and all protections; limitations and restrictions contained in this BAA to Business Associate's use and/or disclosure of any PHI retained after the termination or expiration of this BAA, and shall limit any further uses and/or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

5.4 Cooperation. Each Party shall cooperate in good faith in all respects with the other Party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry.

6. MISCELLANEOUS

6.1 Scope of BAA. This BAA relates only to the use, disclosure and protection of PHI if it is disclosed to, created or received by Business Associate in connection with any relation between Business Associate and Covered Entity, is the sole understanding between the parties relating to such matters, and supersedes all prior BAAs and understandings, whether oral or written.

6.2 Contradictory Terms; Construction of Terms. The terms of this BAA to the extent they are unclear shall be construed to allow for compliance by Covered Entity and Business Associate with HIPAA and ARRA.

6.3 No Third Party Beneficiaries. Nothing in this BAA shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

6.4 Survival. Sections 4.8, 5.3, 5.4, 6.2, 6.3 and 6.4 shall survive the termination for any reason or expiration of this BAA or the BAA.

6.5 Independent Contractor. Business Associate and Covered Entity are and shall remain independent contractors throughout the term. Nothing in this BAA shall be construed to constitute Business Associate and Covered Entity as partners, joint venturers, agents or anything other than independent contractors.

Approved as to form:

County Attorney's Office

The parties, by signing below, agree to this Business Associate Agreement.

Adams County Government

By _____
Authorized Signature

Print Name Terri Lautt

Print Title HR Director

Date 7/5/18

United HealthCare Services, Inc.

By _____
Authorized Signature

Print Name B Renee Feagan

Print Title Regional Contract Manager

Date July 9, 2018

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

AMENDMENT NO. 7

Amendment to be attached to and made a part of Group Policy No. GA-701043AL, issued by UnitedHealthcare Insurance Company (herein called "Company") to Adams County Government (herein called "Policyholder").

It is agreed by and between the Company and the Policyholder that

1. The page entitled "Schedule Of Benefits" as contained in the Policy is hereby replaced with the attached page entitled "Schedule Of Benefits".
2. This Amendment will hereby be effective as of January 1, 2020.

UnitedHealthcare Insurance Company

William J Golden, President

Thomas J. McGuire, Secretary

ACCEPTED BY: _____

Title: _____

Date: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

UHIC AMEND (07/06)

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: Adams County Government

Policy Number: GA-701043AL

Effective Date: January 1, 2020

Administrator: United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2020 through December 31, 2020, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2007 through December 31, 2020 and Paid from January 1, 2020 through December 31, 2020.

Specific Deductible per Covered Person: $300,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: Unlimited

Specific Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Specific Excess Loss Premium: $55.45 per subscriber per month

EXPERIENCE REFUND ENDORSEMENT

Policyholder: Adams County Government

Effective Date: January 1, 2020

In consideration for the premium shown in the Schedule of Excess Loss, the Excess Loss Insurance Policy (the "Policy") will be revised with the addition of Experience Refund Provision.

EXPERIENCE REFUND

The Company will pay the Policyholder an Experience Refund of 25% of Net Profit if the Company issues the Policyholder a Policy/Amendment that provides insurance for a Subsequent Policy Period and insurance is continuous from the first day of the Policy Period through the entire Subsequent Policy Period.

NET PROFIT

Net Profit is calculated as:

a. 60% of the sum of all premiums paid by the Policyholder for the Specific Excess Loss Insurance for the Policy Period; minus

b. the sum of all Specific Excess Loss Insurance claims for the Policy Period.

CALCULATION OF REFUND

Company will calculate and send to the Policyholder, the Experience Refund, if due, 6 months after the end of the Policy Period. A premium credit in the amount of the Experience Refund will be applied to the next available bill.

If Specific Excess Loss Insurance claims are paid after an Experience Refund has been paid to the Policyholder, and such claims relate to the Policy Period for which the Experience Refund has been paid a new Net Profit will be calculated and the Policyholder shall reimburse Company for any reduction in the Experience Refund within thirty (30) days after written notice by the Company. Company may, at its option be reimbursed for any reduction on a previously paid Experience Refund by subtracting the reduced amount from any future payable claim.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

William J Golden, President

Thomas J. McGuire, Secretary

Summary Plan Description

Adams County Government
Choice Plan

Effective: January 1, 2020
Group Number: 701043

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care Coordination℠ and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-847-2744.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

This Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD supersedes any previous printed or electronic SPD for this Plan.

The Plan Administrator intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Plan Administrator is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Adams County Government Choice Health Benefit Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- The Plan Administrator is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee or project designated employee of the Plan Sponsor who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Plan Sponsor who is scheduled to work at least 30 hours per week..

An eligible person also includes designated elected officials who are serving in an active capacity.

An eligible Person also includes a Retired Employee, as defined under (Section 14: Glossary).

Retirees over 65 years of age, actively enrolled in Medicare are not eligible for coverage. Please contact the Plan Administrator for more information regarding your options after Medicare eligibility.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your legal Spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- Domestic Partner (certificate required) as defined in Section 14, *Glossary*.
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.

- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Cost of Coverage

You and the Company share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions may be deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld—and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Adams County Government's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Company reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following date of hire, when date of hire coincides with first of the month then effective immediately. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).

- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Adams County Government's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan Administrator's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. You must see a Network Physician in order to obtain Benefits. Except as specifically described within the SPD, Benefits are not available for services provided by a non-Network provider. This Plan does not provide a non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified by UnitedHealthcare as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider.

Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare. It is your responsibility to select your provider.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition

period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you.

In the event that you do not use the selected Network Physician, Benefits will not be paid.

Designated Provider and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a

Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Benefits will not be paid.

Eligible Expenses

The Company has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by UnitedHealthcare, you will be responsible to the non-Network provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for some Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

This Plan includes an Annual Deductible that applies to certain Covered Health Services. Refer to Section 5, *Plan Highlights*, for details about the specific Covered Health Services to which the Annual Deductible applies.

The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is calculated as a flat dollar amount and is paid at the time of service or when billed by the provider. When Copayments apply, the amount is listed in Section 5, *Plan Highlights*, next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Copays count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following will never apply to the Out-of-Pocket Maximum:

- Charges for Non-Covered Health Services.
- The amount of any reduced benefits if you don't notify the Claims Administrator.
- Charges that exceed eligible expenses.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?
Copays, including those for Covered Health Services available in Section 15, *Outpatient Prescription Drugs*	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination℠	No

SECTION 4 - CARE COORDINATION℠

What this section includes:

- An overview of the Care Coordination℠ program.
- Covered Health Services for which you need to contact Care Coordination℠.

UnitedHealthcare provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care Coordination℠ nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Care CoordinationSM program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- Inpatient care management - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Care Coordination℠ is easy.
Simply call the number on your ID card.

Network providers are generally responsible for notifying the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator is not notified.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.	
■ Emergency Health Services.	$200
■ Physician's Office Services - Primary Physician.	**Designated Network** $30 **Network** $30
■ Physician's Office Services – Specialist Physician.	**Designated Network** $40 **Network** $80
■ Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$30
■ Urgent Care Center Services.	$40
■ Virtual Visits.	$30

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Copays do not apply toward the Annual Deductible. Copays do apply toward the Out-of-Pocket Maximum.	
Annual Deductible ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family). **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$500 $1,000
Annual Out-of-Pocket Maximum ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family). The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services. **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.	$4,500 $9,000

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Benefit ***(The Amount Payable by the Plan based on Eligible Expenses)***
	Designated Network and Network
Ambulance Services	*Ground and/or Air Ambulance*
■ Emergency Ambulance.	95% after you meet the Annual Deductible
■ Non-Emergency Ambulance.	95% after you meet the Annual Deductible
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
See *Cancer Resource Services (CRS)* in Section 6, *Additional Coverage Details*.	
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Congenital Heart Disease (CHD) Surgeries See *Congenital Heart Disease (CHD) Surgeries* in Section 6, *Additional Coverage Details*, for additional details.	95% after you meet the Annual Deductible
Dental Services - Accident Only	95% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Outpatient Prescription Drugs*.
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a Copayment of $200 per visit
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in Section 15, *Outpatient Prescription Drugs*.
Hearing Aids See Section 6, Additional Coverage Details, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Hospital - Inpatient Stay	95% after you meet the Annual Deductible

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*
	Designated Network and Network
Kidney Services For Network Benefits, kidney services must be received by a Designated Provider. *See Kidney Resource Services (KRS) in Section 6, Additional Coverage Details.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Lab, X-Ray and Diagnostics - Outpatient	
■ Lab testing - Outpatient.	100% at a freestanding lab 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab No copayment applies when no Physician charge is assessed.
■ X-ray and Other Diagnostic Testing - Outpatient.	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab No copayment applies when no Physician charge is assessed.
■ PSA Screenings	100%
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Mental Health Services ■ Inpatient. ■ Outpatient. ■ Outpatient – Group Visit.	95% after you meet the Annual Deductible 100% after you pay a Copayment of $30 per visit 100% after you pay a Copayment of $20 per visit 95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Neonatal Resource Services (NRS) For Network Benefits, neonatal services must be received by a Designated Provider. See *Neonatal Resource Services (NRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient. ■ Outpatient – Group Visit.	95% after you meet the Annual Deductible 100% after you pay a Copayment of $30 per visit 100% after you pay a Copayment of $20 per visit 95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Ostomy Supplies	95% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Pharmaceutical Products - Outpatient ■ Primary Physician.	**Designated Network** 100% after you pay a Copayment of $30 per visit **Network** 100% after you pay a Copayment of $30 per visit
■ Specialist Physician.	**Designated Network** 100% after you pay a Copayment of $40 per visit **Network** 100% after you pay a Copayment of $80 per visit
Physician Fees for Surgical and Medical Services	95% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Primary Physician.	**Designated Network** 100% after you pay a Copayment of $30 per visit **Network** 100% after you pay a Copayment of $30 per visit
■ Specialist Physician.	**Designated Network** 100% after you pay a Copayment of $40 per visit **Network** 100% after you pay a Copayment of $80 per visit

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100% 100%
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	100% after you pay a Copayment of $30 per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient. ■ Outpatient – Group Visit.	95% after you meet the Annual Deductible 100% after you pay a Copayment of $30 per visit 100% after you pay a Copayment of $20 per visit 95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	95% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	100% after you pay a Copayment of $30 per visit
Transplantation Services	95% after you meet the Annual Deductible
Travel and Lodging Covered Health Services must be received by a Designated Provider.	For patient and companion(s) of patient undergoing transplant procedures
Urgent Care Center Services	100% after you pay a Copayment of $40 per visit
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $30 per visit

Covered Health Services[1]	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***
	Designated Network and Network
Vision Examinations See Section 6, Additional Coverage Details, for limits.	100% after you pay a Copayment of $30 per visit

[1]Please notify the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to notify the Claims Administrator or Care Coordination℠ before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Care Coordination℠.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Care Coordination℠. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance as UnitedHealthcare determines appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to the closest Network Hospital.
- To the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such

as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.

- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must notify the Claims Administrator as soon as possible prior to the transport.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by a Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or Care Coordination℠.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Pre-Service Notification Requirement
For Benefits you must provide pre-service notification as soon as the possibility of a Cellular or Gene Therapy arises. If you fail to provide pre-service notification as required, No Benefits will be paid.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must notify the Claims Administrator or Care Coordination℠ as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator or Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about

CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Please remember, for Covered Health Services required to be received by a Designated Provider, you must notify the Claims Administrator as soon as the possibility of a CHD surgery arises. If you do not notify the Claims Administrator and if, as a result, the CHD surgeries are not performed by a Designated Provider, Benefits will not be paid.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described is Section 15, *Outpatient Prescription Drugs*.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network will not be provided. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
- Cross-sex hormone therapy:

  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under Section 15, *Outpatient Prescription Drugs*.

- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)
  - Breast Construction

  Female to Male:

  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Surgical Treatment: Please remember, you must notify the Claims Administrator as soon as the possibility for any of surgery arises.

Please call the phone number that appears on your ID card. **Non-Surgical Treatment:** Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this section.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to $3,500 per calendar year for Covered Persons over age 19. Benefits are unlimited to age 19. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits are limited to 275 days during the entire period of time you are covered under this Plan. Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by a Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Care Coordination[SM].
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA,

nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Referral Services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by a Designated Provider participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in Section 14, *Glossary*.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator or Care Coordination℠.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of

what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Office visit copays are waived for the diagnosis and treatment of asthma and or diabetes when no other services are provided.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

No copay applies to office visits after the first visit, unless non routine maternity health services are provided.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.

- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the

appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for occupational therapy.
- 20 visits per calendar year for speech therapy.

- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.
- 24 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Benefits are limited to 60 days per calendar year.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Referral Services.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Care Coordination℠ of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Please remember you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator is not notified, as required, Benefits will be reduced to 50% of Eligible Expenses.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

  The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every other calendar year. Benefits are limited to children up to age 18 only.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

SECTION 7 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

The Company believes in giving you tools to help you be an educated health care consumer. To that end, United Healthcare has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey

You and your enrolled dependents are invited to learn more about health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that are available that may help

you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

- Receive personalized messages that are posted to your own website.
- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM] including Live Nurse Chat 24 hours a day, seven days a week.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays and Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information UnitedHealthcare provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.

- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.

- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

6. The replacement of lost or stolen prosthetic devices.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

9. Powered and non-powered exoskeleton devices.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoe inserts.

6. Arch supports.

7. Shoes (standard or custom), lifts and wedges.

8. Shoe orthotics.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement after initial construction, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.

- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Reversal of genital surgeries.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples:

   - Compression stockings, ace bandages, diabetic strips, and syringes.
   - Urinary catheters.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living Services.

8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

3. Food of any kind. Foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Electric scooters.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.

- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins.
    - Hair removal or replacement by any means.
    - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Skin abrasion procedures performed as a treatment for acne.
    - Treatments for hair loss.
    - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).

13. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

14. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

17. Intracellular micronutrient testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     Assistive reproductive technology.
     Artificial insemination.
     Intrauterine insemination.
     Obtaining and transferring embryo(s).
   - Health care services including:
     Inpatient or outpatient prenatal care and/or preventive care.
     Screenings and/or diagnostic testing.
     Delivery and post-natal care.

   The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.

- Surrogate insurance premiums.
- Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
   - Donor sperm – The cost of procurement and storage of donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

5. The reversal of voluntary sterilization.

6. Fetal reduction surgery.

7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination except. Termination of pregnancy is ONLY covered if mothers' life is at risk and in the event of incest or rape.

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

8. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you, except as otherwise provided by law.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

4. Health services not performed by a Designated Provider.

5. Solid organ Transplant that is performed as a treatment for Cancer.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1.. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 14, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.

- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
- That exceed Eligible Expenses or any specified limitation in this SPD.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to UnitedHealthcare within 15 months of the date of service, Benefits for that health service will be denied or reduced, at UnitedHealthcare's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information

listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology (CPT)* codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a provider with UnitedHealthcare's consent, and the provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and

the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 15 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot

resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.

- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits. For Urgent requests for benefits, the Company has delegated UnitedHealthcare the exclusive right to interpret and administer the terms of the plan. UnitedHealthcare's decisions are conclusive and binding.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the custodial parent; then
  - The parent not having custody of the child; then
  - The Spouse of the non-custodial parent.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become enrolled in Medicare. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is

the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are enrolled in Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Company also reserves the right to recover any overpayment by legal action.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the

amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA), if applicable with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value

of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- Extended coverage.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, the Plan Administrator will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from the Plan Administrator to end your coverage, or the date requested in the notice.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from The Plan Administrator to end your coverage, or the date requested in the notice.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not

limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent, improper use of ID, failure to pay, or threatening behavior. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and the Company find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Adams County Government has the right to demand that you pay back all Benefits Adams County Government paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. Failure to comply with the eligibility requirements as set forth in this SPD may lead to disciplinary action, up to and including, termination of employment.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to the Plan Administrator proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon the Plan Administrator's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Plan Administrator's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- The Total Disability ends.
- Twelve months from the date coverage would have ended.

Continuing Coverage Through COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid, or for a 30-day special enrollment period to enroll in another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified Beneficiaries

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event, such as an employee, the employee's spouse, and dependent children. Dependents continuing coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) are not considered to be Qualified Beneficiaries for COBRA purposes.

A child born to, placed for adoption with, or adopted by the covered employee during a period of COBRA coverage will be considered on the same basis as the covered employee.

Qualifying Events

A Qualifying Event is a life event that would cause the Qualified Beneficiary to lose coverage under the Plan including;

- Termination of employment (other than for gross misconduct), reduction in hours of an eligible employee
- Divorce, legal separation, dependent cessation (a child no longer qualifies as an eligible dependent under the Plan)

- Death of the employee
- Extended military leave of the employee
- Medicare entitlement (Part A, Part B or both) of the employee.

The taking of leave under the Family Medical Leave Act does not constitute a Qualifying Event under COBRA.

COBRA continuation coverage begins on the date that Plan coverage would otherwise have been lost. Qualified Beneficiaries electing continuation coverage must pay 102 percent of the cost of that coverage.

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. For a Qualifying Event such as termination of employment, reduction in hours, death of the employee, or extended military leave of the employee, the employer will notify the Plan Administrator within 31 days of the qualifying event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage. Each Qualified Beneficiary will have an independent right to elect continuation coverage.

You must notify the Plan Administrator in writing in the event of a divorce or legal separation, Medicare entitlement (Part A, Part B or both), or in the event a child no longer qualifies as a dependent, as soon as possible, but no later than 60 days after the date of the Qualifying Event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage.

How long coverage may be continued

- Up to 18 months for the reason of termination of employment (other than for gross misconduct) or reduction in hours of an eligible employee
- Up to 24 months for the reason of continued military leave as defined by USERRA
- Up to 36 months for the reason of death of an employee, a divorce or legal separation, the employee becoming entitled to Medicare benefits (Part A, Part B or both), or a dependent child ceasing to be eligible under the plan
- Up to 36 months for Qualified Beneficiaries, other than the employee, if the Qualifying Event is termination of employment or reduction in hours of the employee, and the employee became entitled to Medicare benefits (Part A, Part B or both) less than 18 months before the Qualifying Event.

Extended Coverage due to Disability

Coverage could be extended up to 11 months, for a total of 29 months of coverage, for all Qualified Beneficiaries if:

- A Qualified Beneficiary is totally disabled according to the Social Security Administration before the 60th day of COBRA continuation coverage, lasting at least until the end of the 18-month period of continuation coverage; and

- The employee or eligible dependent provides the Human Resources Department with a copy of the Social Security Administration (SSA) Determination of Total Disability (notice must be received within the initial 18 months of continued coverage); and
- Timely premium payments are made (premiums are increased to 150 percent of the cost of coverage for the additional 11 months).
- The Plan Administrator must be notified within 31 days if the Qualified Beneficiary is no longer considered disabled by the Social Security Administration.

Employees disabled while continuing coverage under USERRA are not eligible for the 11-month extension rule.

Second Qualifying Events

Coverage for qualified dependents could be extended up to 36 months from the date of the Initial Qualifying Event if:

- The covered employee dies
- A divorce or legal separation from the covered employee occurs
- A covered dependent child no longer qualifies as an eligible dependent
- A covered employee subsequently becomes entitled to Medicare (Part A, Part B or both) during the initial 18-month COBRA period.

These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the Initial Qualifying Event had not occurred. You must notify the Human Resources Department within 60 days after a Second Qualifying Event occurs if you wish to extend coverage.

For Additional Questions

For more information about your rights and obligations under the Plan and federal law you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section *2, Introduction*.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's

Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's termination of coverage under the Plan.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, Adams County Government believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Company and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Company is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Company is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

The Company and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Company and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Company may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the Company does so in any particular case shall not in any way be deemed to require the Company to do so in other similar cases.

Information and Records

The Company and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Company and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The Company and UnitedHealthcare will keep this information confidential. The Company and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Company and UnitedHealthcare with all

information or copies of records relating to the services provided to you. The Company and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. The Company and UnitedHealthcare agree that such information and records will be considered confidential.

The Company and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Plan, The Company and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Company recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Company and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services

related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Plan Highlights*.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and

OptumInsight are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.

- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care Coordination℠ - programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Company - Adams County Government.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, Plan Highlights and Section 6, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that the Claims Administrator has identified as Designated Network providers. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources upon your request.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by some employers and unions.

Employer - Adams County Government.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the

Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
  - ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - ♦ A strong preference for playmates of the other gender.
  - ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - ♦ A strong dislike of ones' sexual anatomy.
  - ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Counseling - counseling by a qualified clinician that includes:

- ■ Identifying your potential risks for suspected genetic disorders;
- ■ An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- ■ Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier- a Gestational Carrier is a woman who agrees to have a couple's fertilized egg (embryo) implanted in her uterus. The gestational carrier carries the pregnancy for the couple, who usually has to adopt the child. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.

- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by the Company, during which eligible Participants may enroll themselves and their Dependents under the Plan. The Company determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Adams County Government Choice Health Benefit Plan.

Plan Administrator - Adams County Government or its designee.

Plan Sponsor - Adams County Government, references to "we", "us" and "our" refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may

suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a

hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

You are responsible for paying the applicable Copayment described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*.

The amount you pay for any of the following under this section will be included in calculating any Out-of-Pocket Maximum stated in your SPD:

- Copayments for Prescription Drug Products.
- Coinsurance for Prescription Drug Products.
- The Annual Drug Deductible.

The amount you pay for any of the following under this section will not be included in calculating any Out-of-Pocket Maximum stated in your SPD:

- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Copay amounts that apply when you have a prescription filled at a Network Pharmacy after you meet the Annual Prescription Drug Deductible. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: An Annual Prescription Drug Deductible of $100 per Covered Person, not to exceed $300 for all Covered Persons in the family applies to your Network Benefits, which is separate from the Annual Deductible for your medical coverage. Copays do not apply toward the Annual Prescription Drug Deductible.

Coupons: UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

The Plan may also require you to notify UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and any Deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Schedule of Benefits - Outpatient Prescription Drugs

Benefit Information for Prescription Drug Products at a Network Pharmacy

Benefit[1,2] **Description and Supply Limits**	**Percentage of Prescription Drug Charge Payable by the Plan:** **(Per Prescription Order or Refill):**
Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2 or Tier 3. Please access **www.myuhc.com** through the Internet or call the telephone number on your ID card to determine tier status.	
Retail The following supply limits apply: As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.[2] A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	100% after you meet the $100 Prescription Drug Deductible per Covered Person, not to exceed $300 for all Covered Persons in the family and pay a:

Benefit[1,2] Description and Supply Limits	Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):
When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment that applies will reflect the number of days dispensed.	
■ Tier-1	100% after you pay a $20 Copay
■ Tier-2	100% after you pay a $40 Copay
■ Tier-3	100% after you pay a $80 Copay
Mail Order Network Pharmacy The following supply limits apply: As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	100% after you meet the $100 Prescription Drug Deductible per Covered Person, not to exceed $300 for all Covered Persons in the family and pay a:
■ Tier-1	100% after you pay a $35 Copay
■ Tier-2	100% after you pay a $90 Copay
■ Tier-3	100% after you pay a $200 Copay

[1]Please notify UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Notification Requirements* in this section.

[2]You are not responsible for paying a Copayment for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Prescription Drug Products Deductible.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drug Products as described in this section, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare Part B.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay after you have met the Annual Prescription Drug Deductible, when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Copay.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copay.
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copay, after meeting the Annual Prescription Drug Deductible. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card. Such preventive drugs are covered at 100%.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

You may fill a prescription for Specialty Prescription Drug Products up to two times at any Network Pharmacy. However, after that you will be directed to a Designated Pharmacy.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Please see *Glossary - Outpatient Prescription Drugs*, in this section for definitions of [4]Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Special Programs

The Company and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement,

reduction or no Benefit through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Adams County Government may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

2. Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.

   - Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.
   - Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement.

   Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

7. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

9. Certain Prescription Drug Products for tobacco cessation.

10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

11. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

12. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

13. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

15. Prescribed, dispensed or intended for use during an Inpatient Stay.

16. Prescribed, dispensed for appetite suppression, and other weight loss products.

17. Prescribed to treat infertility.

18. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and the Company determines do not meet the definition of a Covered Health Service.

19. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

22. Certain unit dose packaging or repackagers of Prescription Drug Products.

23. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and the Company have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*.

24. Used for cosmetic purposes

25. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

26. General vitamins, except for the following which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

27. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

31. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Glossary - Outpatient Prescription Drugs

Annual Drug Deductible (or Prescription Drug Deductible) - the amount that you are required to pay for covered Tier 1, Tier 2 and Tier 3 Prescription Drug Products in a calendar year before the Plan begins paying for Prescription Drug Products. The Annual Prescription Drug Deductible is shown in the table at the beginning of this section.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Prescription Drug Charge – the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.

- Lancets and lancet devices.
- Glucose meters including continuous glucose monitors.

■ Certain vaccines/immunizations administered in a Network Pharmacy.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications(PPACA Zero Cost Share) - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

■ Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

■ With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

■ With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

This Plan is considered a Non-Grandfathered as defined under the Patient Protection and Affordable Care Act (healthcare reform). Therefore, additional benefits may be available to you and your eligible dependents.

- Coverage for approved clinical trials
- Expanded claims appeal
- Habilitative coverage
- Well woman preventive services; i.e. contraceptives paid 100 percent as outlined under the health care reform law
- All co-pays, including prescription drug co-pays, deductibles and co-insurance apply to your out-of-pocket maximum

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT IV – THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

Any Health Risk Assessment (HRA) completed by a person covered by this plan is in compliance with regulations under GINA.

ATTACHMENT V – MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility.

<table>
<tr><th>GEORGIA – Medicaid</th><th>MONTANA – Medicaid</th></tr>
<tr><td>Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084</td></tr>
<tr><th>IDAHO – Medicaid and CHIP</th><th>NEBRASKA – Medicaid</th></tr>
<tr><td>Medicaid Website:
www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588</td><td>Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092</td></tr>
<tr><th>INDIANA – Medicaid</th><th>NEVADA – Medicaid and CHIP</th></tr>
<tr><td>Website:
http://www.in.gov/fssa/2408.htm
Phone: 1-877-438-4479</td><td rowspan="2">Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669</td></tr>
<tr><th>IOWA – Medicaid</th></tr>
</table>

Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid

Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

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

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

ATTACHMENT VI – THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information (PHI). Protected Health Information is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider and identifies you or provides a means by which you could be identified. The Plan and the Plan Sponsor will not use or disclose PHI except for treatment, payment, health plan operations (collectively known as "TPO"), or as permitted or required by other state and federal law, or to Business Associates to help administer the Plan.

Further, the Plan Sponsor will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to HIPAA, your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information (ePHI). ePHI is PHI that is maintained or transmitted in electronic form. The Plan and the Plan Sponsor will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan and Plan Sponsor are separate and independent legal entities, which exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, the Plan Sponsor agrees to, and has certified to the Plan, that it will:

- Restrict the use or further disclosure of PHI except as permitted by HIPAA or as required by law;
- Ensure that any other entity to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- Not use genetic information that is PHI for underwriting purposes;
- Report to the Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- Make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures as required by law;
- Make internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- Provide adequate safeguards to protect PHI;

- Provide legally required notices of unauthorized acquisition, access or disclosures of your health information as required by law; and
- If feasible, upon termination of the plan, 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, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

In order to receive ePHI from the Plan, the Plan Sponsor agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in the Plan document is supported by reasonable and appropriate security measures; and
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information

Only limited members of the workforce of the Group Health Plan may be permitted to use and/or disclose PHI. Under this Plan the following individuals are permitted to have access to, use and/or disclose PHI:

- Employees of the Plan Sponsor who perform administrative services on behalf of the Plan, including payment, health care operations, design and administration. This includes County Administrator, Director of Human Resources, Benefits Manager, Benefits Administrator, Human Resources Specialists.
- Employees of the Plan Sponsor who have access to PHI for purposes of its use by the Employer in performing services for the Plan, including procurement of insurance, financial transactions and accounting. This includes Director of Finance, Administrative Coordinators, Payroll Accountants, Payroll Technicians, General Accounting Managers, Budget Managers and Budget Analysts.
- Service providers to the Plan. This includes County Attorneys, Benefit Consultants, Third Party Administrators, and IT Personnel.

The Plan will limit the use, disclosure or request for PHI to the minimum amount that is reasonably necessary to fulfill a request as set forth in this Agreement. Requests for disclosures other than by legal authority or by the participant will be reviewed by the Privacy Officer or his/her designee.

Where PHI is used or disclosed for the purposes of the Plan's own payment activity, whether through a TPA or Carrier, the employees of the Plan are permitted to use and disclose information to perform these functions using the minimum necessary to accomplish the purpose.

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

You may receive a complete copy of the Plan's Notice of Privacy Practices by contacting the Privacy Officer.

PRIVACY OFFICER

The Plan Administrator has designated a privacy officer who is the contact person for all issues regarding your privacy rights. You may contact the privacy officer at the following address and telephone number.

Director of Human Resources
4430 S. Adams County Parkway, Suite C4000B.
Brighton, CO 80601
phone: 720.523.6070
fax: 720.523.6069

ATTACHMENT VII– HEALTH INSURANCE MARKETPLACE NOTIFICATION

General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes (pre-tax premiums). Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This Plan does meet the minimum value standard for the benefits it provides**.**

ATTACHMENT VIII– GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لطلب مترجم شفهي مجانًا، اتصل برقم الهاتف المجاني الموجود على بطاقة هويتك الصحية واضغط على 0. (TTY: 711)
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4ᏫᎤ ᏏᎵ ᏗCZᎮᏗ Ꮧ4ᏫᎫᏗ ᏂᎪᏯᏪW ᎥᏆ GᏙᎵ VᏋ ᏏR ᏗJJAVᏗ ACᏫᎫVᏗ ᎢΘᏲᏫᎫᏗT, ᎣᏤ0ᵐᏫᎫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါခွဲးတါယာ်လၢနကဘီးနူဉ်ဘဉ်တါမၤစၢၤဒီးတါဂ့ၢ်တါကျိုၤလၢနကျိုဘဉ်နဲဝလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါကယုနူပူၤကတီၤကျိုးထံတါတဂၤအဂီၢ်ကီးဘဉ်လီတဖိအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတ်အိဉ်ဆူဉ်အိဉ်ချအတ်ရဲဉ်တ်ကဲ့ အကးအလိၤဒီးဆီဉ်လီၤနိၣ်ဂ်ၢ် 0 တကွ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	تۆخ ی‌زانی زمان هبتسپێیاری‌لێ و یتەمار‌ی،ر‌ەمار‌ەمبێکەمی‌ە تەموئی‌ەفام ی‌نۆفەتەمار‌ەمبەکبەدی‌ۆ‌ەپ،ی‌کەرازی‌کێڕگێرەو ی‌ندر‌اکاوازۆب.تی‌ڕگێرەو هرگ 0 ان‌اشاپ تۆخ یتی‌وسدنەتنی‌لاپی‌ی‌ەسپێیتار‌اکد ای‌ئاوقلاوار‌سووز .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77

Language	Translated Taglines
	bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíilchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.دهید تماس رایگان ترجمه شفاهی با شماره تلفن رایگان درج شده در کارت شناسایی خود و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia

Language	Translated Taglines
	fa’atalosagaina se tagata fa’aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo”u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܲܚܬܘܿܢ ܐܝܼܬܠܵܘܟ݂ܘܿܢ ܙܲܕܩܘܼܬܵܐ ܕܡܲܩܒܠܝܼܬܘܿܢ ܗܲܝܵܪܬܵܐ ܘܡܲܘܕܥܵܢܘܼܬܵܐ ܒܠܸܫܵܢܵܘܟ݂ܘܿܢ ܡܲܓܵܢܵܐܝܼܬ ܠܩܘܼܒܵܠܵܐ ܕܚܲܕ ܡܲܦܫܩܵܢܵܐ، ܩܪܵܘܢ ܥܲܠ ܡܸܢܝܵܢܵܐ ܕܛܸܠܝܼܦܘܿܢ ܕܐܝܼܬܠܹܗ ܥܲܠ ܟܲܪܛܵܐ ܕܝܼܠܵܟ݂ ܦܵܬܵܐ ܕܣܝܼܡܵܢܵܐ ܘܕܘܼܫ 0. TTY 711.
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non

Language	Translated Taglines
	kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں فہم مدد اور معلومات حاصل کرنے کا حق ہے کیسی ترجمان سے بات کرنے کے لئے مفت فون نمبر پر رکالکریں جو آپ کے میڈیکل آئی ڈی کارڈ پر درج ہے، 0 بٹن۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן קארטל , דרוקט 0. TTY 711 ID
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Summary Plan Description

Adams County Government
Choice Plus Plan with Health Savings Account

Effective: January 1, 2020
Group Number: 701043

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care Coordination℠ and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-847-2744.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

This Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD supersedes any previous printed or electronic SPD for this Plan.

The Plan Administrator intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Plan Administrator is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Adams County Government Choice Plus Health Benefit Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- The Plan Administrator is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee or project designated employee of the Plan Sponsor who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Plan Sponsor who is scheduled to work at least 30 hours per week.

An eligible person also includes designated elected officials who are serving in an active capacity.

An eligible Person also includes a Retired Employee, as defined under (Section 14: Glossary).

Retirees over 65 years of age, actively enrolled in Medicare are not eligible for coverage. Please contact the Plan Administrator for more information regarding your options after Medicare eligibility.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your legal Spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- Domestic Partner (certificate required) as defined in Section 14, *Glossary.*
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.

- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Cost of Coverage

You and the Company share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions may be deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld—and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Adams County Government's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Company reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following date of hire, when date of hire coincides with first of the month then effective immediately. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).

- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Adams County Government's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan Administrator's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Provider and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider, Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

The Company has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare) you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - ♦ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
      - 50% of CMS for the same or similar laboratory service.
      - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
    - ♦ When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
      - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor

that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reute*rs (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for some Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums

for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following will never apply to the Out-of-Pocket Maximum:

- Charges for Non-Covered Health Services.
- The amount of any reduced benefits if you don't notify the Claims Administrator.
- Charges that exceed eligible expenses.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination℠	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - CARE COORDINATION℠

What this section includes:

- An overview of the Care Coordination℠ program.
- Covered Health Services for which you need to contact Care Coordination℠.

UnitedHealthcare provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care Coordination℠ nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Care Coordination℠ program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- Inpatient care management - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Care Coordination℠ is easy.
Simply call the number on your ID card.

Network providers are generally responsible for notifying the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator is not notified.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible		
■ Individual.	$1,400	$2,100
■ Family (not to exceed the Individual amount for all Covered Persons in a family).	$2,800	$4,200
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		
The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.		

Plan Features	Network Amounts	Non-Network Amounts
Annual Out-of-Pocket Maximum ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family). The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services. **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.	 $6,550 $7,900	 $8,000 $16,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited	

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Ambulance Services ■ Emergency Ambulance. ■ Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	*Ground and/or Air Ambulance* Same as Network Same as Network
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider. See *Cancer Resource Services (CRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)		
Congenital Heart Disease (CHD) Surgeries See *Congenital Heart Disease (CHD) Surgeries* in Section 6, *Additional Coverage Details*, for additional details.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	Same as Network
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Outpatient Prescription Drugs*.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Emergency Health Services - Outpatient	80% after you meet the Annual Deductible	Same as Network

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in Section 15, *Outpatient Prescription Drugs*.	
Hearing Aids See Section 6, Additional Coverage Details, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Kidney Services For Network Benefits, kidney services must be received by a Designated Provider. *See Kidney Resource Services (KRS) in Section 6, Additional Coverage Details.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Lab, X-Ray and Diagnostics - Outpatient		
■ Lab testing - Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ X-ray and Other Diagnostic Testing - Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ PSA Screenings	100%	50% after you meet the Annual

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
		Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible 80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Neonatal Resource Services (NRS) For Network Benefits, neonatal services must be received by a Designated Provider. See *Neonatal Resource Services (NRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible 80% for Partial Hospitalization/Intensive Outpatient Treatment after you	50% after you meet the Annual Deductible 50% for Partial Hospitalization/Intensive Outpatient Treatment after you

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
	meet the Annual Deductible	meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100% 100%	Non-Network Benefits are not available
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	50% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible	Non-Network Benefits are not available
Travel and Lodging Covered Health Services must be received by a Designated Provider.	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available
Vision Examinations See Section 6, Additional Coverage Details, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

[1]Please notify the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to notify the Claims Administrator or Care Coordination℠ before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Care Coordination℠.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Care Coordination℠. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify the Claims Administrator as soon as possible before transport.

If the Claims Administrator or Care Coordination℠, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by a Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or Care Coordination℠.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Pre-Service Notification Requirement
For Network Benefits you must provide pre-service notification as soon as the possibility of a Cellular or Gene Therapy arises. If you do not provide pre-service notification and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must notify the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.

- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as the possibility of a CHD surgery arises.

For Non-Network Benefits, if the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Any combination of Network Benefits and Non-Network Benefits is limited to $3,000 per calendar year. Benefits are further limited to a maximum of $900 per tooth.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon the medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described is Section 15, *Outpatient Prescription Drugs*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than $1,000. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.

- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Please remember for Non-Network Benefits, you must notify the Claims Administrator if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible

Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

> Please remember for Non-Network Benefits, you must notify the Claims Administrator within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under Section 15, *Outpatient Prescription Drugs*.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)
  - Breast Construction

  Female to Male:

  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)

- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Surgical Treatment: Please remember, you must notify the Claims Administrator as soon as the possibility for any of surgery arises.

Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Non-Surgical Treatment: Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this section.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $3,500 per calendar year for Covered Persons over age 19. Benefits are unlimited to age 19. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Please remember for Non-Network Benefits, that you must notify the Claims Administrator five business days before receiving services or as soon as reasonably possible. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits are limited to 275 days during the entire period of time you are covered under this Plan.

Please remember for Non-Network Benefits, you must notify the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you [5]mustnotify the Claims Administrator as follows:

- For scheduled admissions: five business days before admission or as soon as reasonably possible.
- For non-scheduled admissions (including Emergency admissions): as soon as is reasonably possible.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by a Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Care Coordination[SM].
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA,

nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

For Non-Network Benefits for Genetic Testing and sleep studies, you must notify the Claims Administrator five business days before scheduled services are received. If you fail to notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.

- Provider-based case management services.
- Crisis intervention.
- Referral Services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive these Benefits. For a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must provide notification five business days in advance of the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must notify the Claims Administrator before the following services are received. Services requiring notification: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

Please call the number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by a Designated Provider participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in Section 14, *Glossary*.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator or Care Coordination℠.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.

- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive these Benefits. Scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management. Pre-service notification is also required for Benefits provided for Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

For Non-Network Benefits you must notify the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic

function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. When you provide notification, the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment

is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Any combination of Network Benefits and Non-Network Benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for occupational therapy.
- 20 visits per calendar year for speech therapy.
- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.
- 24 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as follows:

- For a scheduled admission: five business days before admission.
- For a non-scheduled admission within one business day or as soon as is reasonably possible.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Referral Services.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator for these Benefits in advance of any treatment. A scheduled admission for Substance-Related and Addictive Disorder Services (including an admission for services at a Residential Treatment facility) you must provide notification five business days in advance of the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received. Services requiring advance notification: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

For Non-Network Benefits for blepharoplasty uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries, cochlear implant you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator for the following outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. Services that require notification: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound. If the Claims Administrator is not notified, as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Care Coordination℠ of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Please remember for Network Benefits you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator is not notified and if, as a result, the services are not performed by a Designated Provider, Network Benefits will not be paid.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care by a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.

- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

  The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every other calendar year. Benefits are limited to children up to age 18 only.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

SECTION 7 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

The Company believes in giving you tools to help you be an educated health care consumer. To that end, United Healthcare has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey

You and your enrolled dependents are invited to learn more about health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that are available that may help

you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

- Receive personalized messages that are posted to your own website.
- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM] including Live Nurse Chat 24 hours a day, seven days a week.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information UnitedHealthcare provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.

- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.

- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

6. The replacement of lost or stolen prosthetic devices.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

9. Powered and non-powered exoskeleton devices.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoe inserts.

6. Arch supports.

7. Shoes (standard or custom), lifts and wedges.

8. Shoe orthotics.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement after initial construction, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.

- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Reversal of genital surgeries.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples:

   - Compression stockings, ace bandages, diabetic strips, and syringes.
   - Urinary catheters.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living Services.

8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a

disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

3. Food of any kind. Foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Electric scooters.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.

- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).

13. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

14. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons

because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

17. Intracellular micronutrient testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     Assistive reproductive technology.
     Artificial insemination.
     Intrauterine insemination.
     Obtaining and transferring embryo(s).
   - Health care services including:
     Inpatient or outpatient prenatal care and/or preventive care.
     Screenings and/or diagnostic testing.
     Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
   - Donor sperm – The cost of procurement and storage of donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

5. The reversal of voluntary sterilization.

6. Fetal reduction surgery.

7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination except. Termination of pregnancy is ONLY covered if mothers' life is at risk and in the event of incest or rape.

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

8. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you, except as otherwise provided by law.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare

determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

4. Health services not performed by a Designated Provider.

5. Solid organ Transplant that is performed as a treatment for Cancer.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.
4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 14, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion

does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
- That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
- That exceed Eligible Expenses or any specified limitation in this SPD.
- For which a non-Network provider waives the Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to UnitedHealthcare within 15 months of the date of service, Benefits for that health service will be denied or reduced, at UnitedHealthcare's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information

listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology (CPT)* codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Adams County Government reserves the right to offset Benefits

to be paid to the provider by any amounts that the provider owes Adams County Government (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 15 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain

maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits. For Urgent requests for benefits, the Company has delegated UnitedHealthcare the exclusive right to interpret and administer the terms of the plan. UnitedHealthcare's decisions are conclusive and binding.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the custodial parent; then
  - The parent not having custody of the child; then
  - The Spouse of the non-custodial .
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- If, based on the allowable expense, the Plan would have paid more if it were the only plan involved, the difference between the amount it would have paid and the amount it actually paid is recorded as a benefit reserve for the Covered Person. This reserve can be used to pay any future allowable expenses not otherwise paid by the Plan during the calendar year.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become enrolled in Medicare. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are enrolled in Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Company also reserves the right to recover any overpayment by legal action.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the

overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA),if applicable with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value

of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- Extended coverage.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, the Plan Administrator will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from the Plan Administrator to end your coverage, or the date requested in the notice.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from the Plan Administrator to end your coverage, or the date requested in the notice.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not

limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent, improper use of ID, failure to pay, or threatening behavior. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and the Company find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Adams County Government has the right to demand that you pay back all Benefits Adams County Government paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. Failure to comply with the eligibility requirements as set forth in this SPD may lead to disciplinary action, up to and including, termination of employment.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to the Plan Administrator proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon the Plan Administrator's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Plan Administrator's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- The Total Disability ends.
- twelve months from the date coverage would have ended.

Continuing Coverage Through COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan. When you become eligible for COBRA, you may also become eligible for other coverage options

that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid, or for a 30-day special enrollment period to enroll in another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified Beneficiaries

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event, such as an employee, the employee's spouse, and dependent children. Dependents continuing coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) are not considered to be Qualified Beneficiaries for COBRA purposes.

A child born to, placed for adoption with, or adopted by the covered employee during a period of COBRA coverage will be considered on the same basis as the covered employee.

Qualifying Events

A Qualifying Event is a life event that would cause the Qualified Beneficiary to lose coverage under the Plan including;

- Termination of employment (other than for gross misconduct), reduction in hours of an eligible employee
- Divorce, legal separation, dependent cessation (a child no longer qualifies as an eligible dependent under the Plan)
- Death of the employee
- Extended military leave of the employee

- Medicare entitlement (Part A, Part B or both) of the employee.

The taking of leave under the Family Medical Leave Act does not constitute a Qualifying Event under COBRA.

COBRA continuation coverage begins on the date that Plan coverage would otherwise have been lost. Qualified Beneficiaries electing continuation coverage must pay 102 percent of the cost of that coverage.

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. For a Qualifying Event such as termination of employment, reduction in hours, death of the employee, or extended military leave of the employee, the employer will notify the Plan Administrator within 31 days of the qualifying event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage. Each Qualified Beneficiary will have an independent right to elect continuation coverage.

You must notify the Plan Administrator in writing in the event of a divorce or legal separation, Medicare entitlement (Part A, Part B or both), or in the event a child no longer qualifies as a dependent, as soon as possible, but no later than 60 days after the date of the Qualifying Event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage.

How long coverage may be continued

- Up to 18 months for the reason of termination of employment (other than for gross misconduct) or reduction in hours of an eligible employee
- Up to 24 months for the reason of continued military leave as defined by USERRA
- Up to 36 months for the reason of death of an employee, a divorce or legal separation, the employee becoming entitled to Medicare benefits (Part A, Part B or both), or a dependent child ceasing to be eligible under the plan
- Up to 36 months for Qualified Beneficiaries, other than the employee, if the Qualifying Event is termination of employment or reduction in hours of the employee, and the employee became entitled to Medicare benefits (Part A, Part B or both) less than 18 months before the Qualifying Event.

Extended Coverage due to Disability

Coverage could be extended up to 11 months, for a total of 29 months of coverage, for all Qualified Beneficiaries if:

- A Qualified Beneficiary is totally disabled according to the Social Security Administration before the 60th day of COBRA continuation coverage, lasting at least until the end of the 18-month period of continuation coverage; and
- The employee or eligible dependent provides the Human Resources Department with a copy of the Social Security Administration (SSA) Determination of Total Disability (notice must be received within the initial 18 months of continued coverage); and

- Timely premium payments are made (premiums are increased to 150 percent of the cost of coverage for the additional 11 months).
- The Plan Administrator must be notified within 31 days if the Qualified Beneficiary is no longer considered disabled by the Social Security Administration.

Employees disabled while continuing coverage under USERRA are not eligible for the 11-month extension rule.

Second Qualifying Events

Coverage for qualified dependents could be extended up to 36 months from the date of the Initial Qualifying Event if:

- The covered employee dies
- A divorce or legal separation from the covered employee occurs
- A covered dependent child no longer qualifies as an eligible dependent
- A covered employee subsequently becomes entitled to Medicare (Part A, Part B or both) during the initial 18-month COBRA period.

These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the Initial Qualifying Event had not occurred. You must notify the Human Resources Department within 60 days after a Second Qualifying Event occurs if you wish to extend coverage.

For Additional Questions

For more information about your rights and obligations under the Plan and federal law you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's termination of coverage under the Plan.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, Adams County Government believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Company and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Company is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Company is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

The Company and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Company and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Company may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the Company does so in any particular case shall not in any way be deemed to require the Company to do so in other similar cases.

Information and Records

The Company and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Company and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The Company and UnitedHealthcare will keep this information confidential. The Company and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Company and UnitedHealthcare with all

information or copies of records relating to the services provided to you. The Company and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. The Company and UnitedHealthcare agree that such information and records will be considered confidential.

The Company and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Plan, the Company and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Company recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Company and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment

and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Plan Highlights*.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and

OptumInsight are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.

- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care Coordination℠ - programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Company - Adams County Government.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, Plan Highlights and Section 6, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.

- They must be financially interdependent.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by some employers and unions.

Employer - Adams County Government.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at

the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - ♦ A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - ♦ A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - ♦ A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - ♦ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - ♦ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - ♦ A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

■ Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
  - ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - ♦ A strong preference for playmates of the other gender.
  - ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - ♦ A strong dislike of ones' sexual anatomy.
  - ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Counseling - counseling by a qualified clinician that includes:

■ Identifying your potential risks for suspected genetic disorders;

- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier- a Gestational Carrier is a woman who agrees to have a couple's fertilized egg (embryo) implanted in her uterus. The gestational carrier carries the pregnancy for the couple, who usually has to adopt the child. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples

include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by the Company, during which eligible Participants may enroll themselves and their Dependents under the Plan. The Company determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Adams County Government Choice Plus Health Benefit Plan.

Plan Administrator - Adams County Government or its designee.

Plan Sponsor - Adams County Government, references to "we", "us" and "our" refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private

Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and

drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Coinsurance described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy after you meet the Annual Deductible. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

The Plan may also require you to notify UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician, are responsible for notifying UnitedHealthcare as required.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. UnitedHealthcare contracted pharmacy reimbursement rates (UnitedHealthcare's Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Coinsurance and any deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Schedule of Benefits - Outpatient Prescription Drugs

Benefit Information for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy

Covered Health Services[1,2,3]	**Percentage of Prescription Drug Charge Payable by the Plan:**	**Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:**
	Network	**Non-Network**
Retail - up to a 31-day supply		
■ Tier-1	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Tier-2	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Tier-3	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Specialty Prescription Drug Products - As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.		
■ Tier-1	80% after you meet the Annual Deductible	Not Covered

Covered Health Services[1,2,3]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	**Non-Network**
■ Tier-2	80% after you meet the Annual Deductible	Not Covered
■ Tier-3	80% after you meet the Annual Deductible	Not Covered
Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.		
Mail order - up to a 90-day supply		
■ Tier-1	80% after you meet the Annual Deductible	Not Covered
■ Tier-2	80% after you meet the Annual Deductible	Not Covered
■ Tier-3	80% after you meet the Annual Deductible	Not Covered

[1]Please notify UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Prior Authorization Requirements* in this section.

[2]The Plan pays Benefits for Specialty Prescription Drug Products as described in this table.

[3]You are not responsible for paying a Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drug Products as described in this section,

except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare Parts B and D.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Coinsurance, which is the amount you pay after you have met the Annual Deductible, when you visit the pharmacy or order your medications through mail order. Your Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Coinsurance option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Coinsurance option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug at a non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Coinsurance.
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with UnitedHealthcare, as described in your SPD, *Section 9*, *Claims Procedures*. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Coinsurance, after meeting the Annual Deductible. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Coinsurance that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products. You may fill a prescription for Specialty Prescription Drug Products up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Please see *Glossary - Outpatient Prescription Drugs*, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Special Programs

Adams County Government and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Adams County Government may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine

whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

2. Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

   This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

7. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*.

Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

8. Certain Prescription Drug Products for tobacco cessation.

9. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

10. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

11. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

12. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

14. Prescribed, dispensed or intended for use during an Inpatient Stay.

15. Prescribed, dispensed for appetite suppression, and other weight loss products.

16. Prescribed to treat infertility.

17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service.

18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain unit dose packaging or repackagers of Prescription Drug Products.

22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Adams County Government have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*.

23. Used for cosmetic purposes

24. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

25. General vitamins, except for the following which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

26. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. Dental products, including but not limited to prescription fluoride topicals.

29. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

31. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Glossary - Outpatient Prescription Drugs

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the

manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Out-of-Network Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Prescription Drug Charge - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than

six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous glucose monitors.
- Certain vaccines/immunizations administered in a Network Pharmacy.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications (PPACA Zero Cost Share) - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Coinsurance or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

This Plan is considered a Non-Grandfathered as defined under the Patient Protection and Affordable Care Act (healthcare reform). Therefore, additional benefits may be available to you and your eligible dependents.

- Coverage for approved clinical trials
- Expanded claims appeal
- Habilitative coverage
- Well woman preventive services; i.e. contraceptives paid 100 percent as outlined under the health care reform law
- All co-pays, including prescription drug co-pays, deductibles and co-insurance apply to your out-of-pocket maximum

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT III - HEALTH SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts.
- Who is eligible and how to enroll.
- Contributions.
- Additional medical expense coverage available with your Health Savings Account.
- Using the HSA for Non-Qualified Expenses.
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Adams County Government health benefit Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

Adams County Government has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by Adams County Government. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles, Copayments or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- Adams County Government health benefit Plan, a high deductible medical plan which is discussed in your Summary Plan Description.
- An HSA you establish.
- Health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

What is an HSA?
An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA).
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare).
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles, Copayments and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Adams County Government and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Adams County Government and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this

information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ATTACHMENT IV – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT V – THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

Any Health Risk Assessment (HRA) completed by a person covered by this plan is in compliance with regulations under GINA.

ATTACHMENT VI – MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility**.**

<table>
<tr><td>GEORGIA – Medicaid</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084</td></tr>
<tr><td>IDAHO – Medicaid and CHIP</td><td>NEBRASKA – Medicaid</td></tr>
<tr><td>Medicaid Website:
www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588</td><td>Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092</td></tr>
<tr><td>INDIANA – Medicaid</td><td>NEVADA – Medicaid and CHIP</td></tr>
<tr><td>Website:
http://www.in.gov/fssa/2408.htm
Phone: 1-877-438-4479</td><td rowspan="2">Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669</td></tr>
<tr><td>IOWA – Medicaid</td></tr>
</table>

Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid

Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

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

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

ATTACHMENT VII – THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information (PHI). Protected Health Information is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider and identifies you or provides a means by which you could be identified. The Plan and the Plan Sponsor will not use or disclose PHI except for treatment, payment, health plan operations (collectively known as "TPO"), or as permitted or required by other state and federal law, or to Business Associates to help administer the Plan.

Further, the Plan Sponsor will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to HIPAA, your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information (ePHI). ePHI is PHI that is maintained or transmitted in electronic form. The Plan and the Plan Sponsor will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan and Plan Sponsor are separate and independent legal entities, which exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, the Plan Sponsor agrees to, and has certified to the Plan, that it will:

- Restrict the use or further disclosure of PHI except as permitted by HIPAA or as required by law;
- Ensure that any other entity to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- Not use genetic information that is PHI for underwriting purposes;
- Report to the Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- Make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures as required by law;
- Make internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- Provide adequate safeguards to protect PHI;

- Provide legally required notices of unauthorized acquisition, access or disclosures of your health information as required by law; and
- If feasible, upon termination of the plan, 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, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

In order to receive ePHI from the Plan, the Plan Sponsor agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in the Plan document is supported by reasonable and appropriate security measures; and
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information

Only limited members of the workforce of the Group Health Plan may be permitted to use and/or disclose PHI. Under this Plan the following individuals are permitted to have access to, use and/or disclose PHI:

- Employees of the Plan Sponsor who perform administrative services on behalf of the Plan, including payment, health care operations, design and administration. This includes County Administrator, Director of Human Resources, Benefits Manager, Benefits Administrator, Human Resources Specialists.
- Employees of the Plan Sponsor who have access to PHI for purposes of its use by the Employer in performing services for the Plan, including procurement of insurance, financial transactions and accounting. This includes Director of Finance, Administrative Coordinators, Payroll Accountants, Payroll Technicians, General Accounting Managers, Budget Managers and Budget Analysts.
- Service providers to the Plan. This includes County Attorneys, Benefit Consultants, Third Party Administrators, and IT Personnel.

The Plan will limit the use, disclosure or request for PHI to the minimum amount that is reasonably necessary to fulfill a request as set forth in this Agreement. Requests for disclosures other than by legal authority or by the participant will be reviewed by the Privacy Officer or his/her designee.

Where PHI is used or disclosed for the purposes of the Plan's own payment activity, whether through a TPA or Carrier, the employees of the Plan are permitted to use and disclose information to perform these functions using the minimum necessary to accomplish the purpose.

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

You may receive a complete copy of the Plan's Notice of Privacy Practices by contacting the Privacy Officer.

PRIVACY OFFICER

The Plan Administrator has designated a privacy officer who is the contact person for all issues regarding your privacy rights. You may contact the privacy officer at the following address and telephone number.

Director of Human Resources
4430 S. Adams County Parkway, Suite C4000B.
Brighton, CO 80601
phone: 720.523.6070
fax: 720.523.6069

ATTACHMENT VIII– HEALTH INSURANCE MARKETPLACE NOTIFICATION

General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes (pre-tax premiums). Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This Plan does meet the minimum value standard for the benefits it provides**.**

ATTACHMENT VIV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

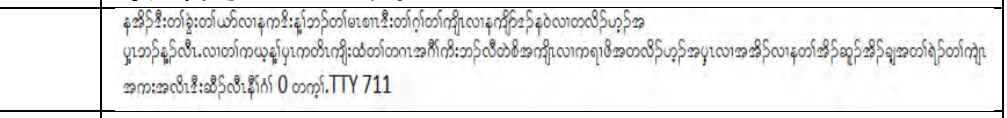
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամնէրի հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮻ ᏏᏢ ᏗCZᏢᏗ Ꮧ4ᏫᎫᏗ ᏥAᏯW ᎥᏓ GᏙᏢ VᏍ ᏏR ᏗJAVᏗ ACᏫᎫVᏗ ᎢΘᏲᏫᎫᏗT, ᎣᏤ0ᏼᏫᎫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کەبێبەرامبەر، یارمەتی و زانیاریپێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەگێڕانی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yínízeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0

Language	Translated Taglines
	bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le

Language	Translated Taglines
	totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܢܬܘܢ ܐܝܬܠܟܘܢ ܙܕܩܘܬܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ ܠܫܘܐܠܬܐ ܥܠ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܛܠܦܘܢ ܕܐܝܬܠܗ ܒܟܪܛܝܣ ܗܘܝܬܐ ܕܬܘܟܠܬܐ ܘܕܘܫܘ 0. TTY 711.
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an

Language	Translated Taglines
	noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

SUMMARY PLAN DESCRIPTION

Adams County Government Medical
Select Doctors Plan

Effective: January 1, 2020

Group Number: 701043

UnitedHealthcare®

Summary Plan Description Table of Contents

Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Health Care Services available to you under the Adams County Government ("Plan Sponsor") Self-Funded health benefit plan. This *SPD* is a legal document that describes Benefits for the portion of the Plan for which United Healthcare Services, Inc. ("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD*, the Plan includes:

- The *Schedule of Benefits.*
- Amendments.
- Addendums.
- Summary Material Modification (SMM).

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, SMM or Amendment.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval.

On its effective date, this *SPD* replaces and overrules any *SPD* that the Plan Sponsor may have previously issued to you. This *SPD* will in turn be overruled by any *SPD* issued to you in the future.

The Plan will take effect on the date shown in the Plan. Coverage under the Plan starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not an employee health and welfare plan as defined by ERISA.

Introduction to Your SPD

This *SPD* and the other Plan documents describe your Benefits, as well as your rights and responsibilities, under the Plan.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *SPD* and any attached Summary Material Modifications (SMMs) and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *SPD* at www.myuhc.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as a Participant or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Plan Sponsor may require you to make certain payments to them, in order for you to remain enrolled under the Plan. If you have questions about this, contact your Plan Sponsor.

Be Aware the Plan Does Not Pay for All Health Care Services

The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. The Plan will pay Benefits as of the day your coverage begins under the Plan for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

Plan Sponsor and the Claims Administrator make administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. Plan Sponsor's and the Claims Administrator's decisions are for payment purposes only. Plan Sponsor and the Claims Administrator do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Plan Sponsor and the Claims Administrator have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and any SMMs and/or Amendments.
- Make factual determinations relating to Benefits.

Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, the Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings the Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to the Claims Administrator's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

The Claims Administrator may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but it is recommended that you discuss them with your Physician.

UnitedHealthcare Select

United Healthcare Services, Inc.

Schedule of Benefits

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Participant in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP*. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Participant for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. You do not need a referral from a Primary Care Physician and may seek care directly from a Specialist, including a Physician who specializes in obstetrics or gynecology.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits,* Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Benefits for facility services apply when Covered Health Care Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or an out-of-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Care Services.

Depending on the geographic area and the service you receive, you may have access through the Claims Administrator's Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. In general, Network providers are responsible for obtaining prior authorization before they provide these

services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator's final coverage determination will be changed to account for those differences, and the Plan will only pay and the Claims Administrator will only process payments for Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments for the Plan as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain prior authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term and Description Table

Payment Term And Description	Amounts
	The Amount You Pay **Network**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. **Coupons:** The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	***Network*** No Annual Deductible.
Out-of-Pocket Limit	
The maximum you pay per year for Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts. **Coupons:** The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	***Network*** For single coverage, the Out-of-Pocket Limit is $2,000. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is $4,500. The Out-of-Pocket Limit includes the Annual Deductible.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount.	

Payment Term And Description	Amounts
	The Amount You Pay **Network**
Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Ambulance Services		
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible before transport.		
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Not Applicable *Air Ambulance:* Not Applicable	
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	Ground or air ambulance, as the Claims Administrator determines appropriate.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	*Ground Ambulance:* Not Applicable *Air Ambulance:* Not Applicable	
Cellular and Gene Therapy		
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Clinical Trials		
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Congenital Heart Disease (CHD) Surgeries		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Dental Services - Accident Only		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. You must purchase, rent, or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Emergency Health Care Services - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per Visit	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Gender Dysphoria		
Prior Authorization Requirement for Surgical Treatment You must obtain prior authorization as soon as the possibility of surgery arises. **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Chiropractic/Manipulative Treatment $30 per visit All other therapies $15 per Visit	Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation*

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		Services - Outpatient Therapy and Manipulative Treatment.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hearing Aids		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $3,500 every year for Covered Persons over age 19. Benefits are unlimited to age 19. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Home Health Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Hospice Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hospital - Inpatient Stay		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Infertility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Diagnosis and treatment of medical condition causing infertility. No coverage for: • Services and related expenses for infertility treatments. • Surrogate parenting, donor eggs, donor sperm and host uterus.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$25 per service $150 per service at a Hospital-based lab	If the service is provided in a doctor's office, additional co-pays, deductible or co-insurance may apply. Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$25 per service $150 per service at an outpatient Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Prostate Specific Antigen Test What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not applicable	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per service $250 per service at an outpatient Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None per visit *Partial Hospitalization/Intensive Outpatient Treatment* $250 per session for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Ostomy Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	No coverage for: • deodorants • filters • lubricants • tape • appliance cleaners • adhesive and remover • other items not listed
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Pharmaceutical Products - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Physician Fees for Surgical and Medical Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Physician's Office Services - Sickness and Injury		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care Physician* None per visit for a Primary Care Physician office visit or $75 per visit for a Specialist office visit	In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
	20% per visit for home visits	the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Pregnancy - Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay*.	
Preventive Care Services		
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Prosthetic Devices		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Chiropractic/Manipulative Treatment $30 per visit Pulmonary Rehabilitation Therapy $30 per visit All other therapies $15 per Visit	Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 24 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		• 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per calendar year combined with *Habilitative Inpatient Services*. No coverage for: • Custodial care or maintenance care • Domiciliary care • Respite care, except when part of hospice care. • Services of personal care attendants • Individualized treatment programs designed to prepare a person for work.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Surgery - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$200 per date of service	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Therapeutic Treatments - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Transplantation Services		
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		
What Is the Copayment or Coinsurance You Pay? This	None	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
May Include a Copayment, Coinsurance or Both.		following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Virtual Visits		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Vision Exams		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Covered only for children up to age 18. Limited to 1 exam every 2 years.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	No coverage for: • Glasses and contact lenses, including fitting charges. • Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Surgery that allows you to see better without glasses or other vision correction (such as Lasik surgery).
Does the Annual Deductible Apply?	Not Applicable	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. Allowed Amounts are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the *SPD*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Allowed Amounts are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not Adams County Government or the Claims Administrator's employees. It is your responsibility to choose your provider.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claims Administrator's products. Refer to your provider directory or contact the Claims Administrator for help.

Additional Network Availability

Certain Covered Health Care Services defined below may also be provided through the *W500* Network. Contact **www.myuhc.com** or the telephone number on your ID card for the *W500* provider directory. You are eligible for Benefits when these certain Covered Health Care Services are received from providers who are contracted with the Claims Administrator through the *W500* Network.

These Covered Health Care Services are limited to the services listed below, as described in *Section 1: Covered Health Care Services*:

- *Emergency Health Care Services - Outpatient.*
- *Hospital - Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Care Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Care Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if the Claims Administrator determines that specific Covered Health Care Services are not available from a Doctors Plan Network provider, you may be eligible for Benefits when Covered Health Care Services are received from a *W500* Network provider. In this situation, before you receive these Covered Health Care Services, your Doctors Plan Plus Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that the Covered Health Care Services are not available from a Doctors Plan Plus Network provider, the Claims Administrator will work with you and your Doctors Plan Plus Network Physician to coordinate these Covered Health Care Services through a *W500* Network provider.

Designated Providers

If you have a medical condition that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Care Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, the Plan may reimburse certain travel expenses.

In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.

  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.

- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Plan*.

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *SPD*.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
    - Licensed speech-language pathologist.
    - Licensed audiologist.
    - Licensed occupational therapist.

  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, the Claims Administrator may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *SPD*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Infertility Services

Diagnosis and treatment of medical condition causing infertility.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Presumptive Drug Tests and Definitive Drug Tests.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.

- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis* (*ABA*)) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Plan.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, the Claims Administrator may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

The Claims Administrator also has special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify the Claims Administrator regarding your Pregnancy.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented.
  - Duration of a rental.
  - Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

Donor costs that are directly related to organ removal are Covered Health Care Services for which Benefits are payable through the organ recipient's coverage under the Plan.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio with video technology or audio only outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Exams

Routine vision exams received from a health care provider in the provider's office for Covered Persons over the age of 18.

Section 2: Exclusions and Limitations

How Are Headings Used in this Section?

To help you find exclusions, this section contains headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.
4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
8. Powered and non-powered exoskeleton devices.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 1, *Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only

available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:
   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.

- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
    - Nutritional education is required for a disease in which patient self-management is a part of treatment.
    - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot and cold compresses.
    - Hot tubs.
    - Humidifiers.

- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke.
8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
15. Helicobacter pylori (H. pylori) serologic testing.
16. Intracellular micronutrient testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
    - Has not been involved in your medical care prior to ordering the service, or

- Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

Reproduction

1. The following services related to a Gestational Carrier or Surrogate:
   - All costs related to reproductive techniques including:
     - Assistive reproductive technology.
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
     - Surrogate insurance premiums.
     - Travel or transportation fees.
2. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under Infertility Services including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
   - Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under Infertility Services including thawing and insemination.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination except. Termination of pregnancy is ONLY covered if mothers' life is at risk and in the event of incest or rape.

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
7. In vitro fertilization regardless of the reason for treatment.

Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Plan Sponsor's that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health services for transplants involving animal organs.

Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long-term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).

3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Plan.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Plan Sponsor. The Plan Sponsor will submit the completed forms to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

To enroll, call the Plan Sponsor within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and the Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld. In most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of the Plan Sponsor's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Plan Sponsor.

What If You Are Hospitalized When Your Coverage Begins?

The Plan will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Plan.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify the Claims Administrator of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providerWhat If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B, except as specified under law.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

The Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

You are eligible to enroll in the Plan if you are a regular full-time employee or project designated employee of the Plan Sponsor who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Plan Sponsor who is scheduled to work at least 30 hours per week.

An eligible person also includes designated elected officials who are serving in an active capacity and Economic Development employees working at least 30 hours per week.

An Eligible Person also includes a Retired Employee, as defined under *Section 9: Defined Terms*.

Retirees over 65 years of age, actively enrolled in Medicare are not eligible for coverage. Please contact the Plan Administrator for more information regarding your options after Medicare eligibility.

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For a complete definition of Eligible Person, Plan Sponsor and Participant, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

Dependent

An eligible Dependent is considered to be:

- Your legal Spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- Domestic Partner (certificate required) as defined in Section 9, *Defined Terms.*
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.
- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Plan Sponsor sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Participant's may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.

- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

  Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Participant," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice.

- **Participants Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the last day of the calendar month in which the Participant is retired or receiving benefits under the Plan Sponsor 's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Plan, and only if the Participant continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Participant that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, the Plan Sponsor may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan Sponsor's request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by the Claims Administrator. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

How Are Outpatient Prescription Drug Benefits Paid?

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Participant's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with the Claims Administrator at the address on your ID card.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an out-of-Network provider without the Claims Administrator's consent. When an assignment is not obtained, the Claims Administrator will send the reimbursement directly to the Participant for reimbursement to an out-of-Network provider. The Claims Administrator reserves the right, in its discretion, to process Plan payment to an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, the Plan has the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan.

When you assign your Benefits under the Plan to an out-of-Network provider with the Claims Administrator's consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, the Claims Administrator may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in *Section 8: General Legal Provisions.*

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Claims Administrator in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Claims Administrator will notify you of the decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

For medical claims, the appeals address is:

UnitedHealthcare - Appeals

P.O. Box 30432,

Salt Lake City, Utah 84130-0432

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Claims Administrator.
- The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the Claims Administrator at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. The Claims Administrator have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the *IRO*.
- A decision by the *IRO.*

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned *IRO* the documents and information considered in making the Claims Administrator's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the Claims Administrator receives a *Final External Review Decision* reversing the Claims Administrator's determination, the Claims Administrator will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with the determination, the Claims Administrator will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
    - The life or health of the individual.
    - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
    - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
    - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an *IRO* in the same manner the Claims Administrator utilizes to assign standard external reviews to *IRO*s. The Claims Administrator will provide all required documents and information the Claims Administrator used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the Claims Administrator at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
    - The parents are married or living together whether or not they have ever been married and not legally separated.
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary, it determines the amount it will pay for a Covered Health Care Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an allowable expense? For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "*Determining the Allowable Expense When this Plan is Secondary to Medicare*".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge - often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare - typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Who has the Right to Receive and Release Needed Information?

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of you, you, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all treatments you or your Physician may believe are needed. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The Claims Administrator has agreements in place that govern the relationships between it and Plan Sponsors and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Care Services to Covered Persons.

Plan Sponsors and the Claims Administrator do not provide health care services or supplies, or practice medicine. Plan Sponsors and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not the Plan Sponsor's employees. Network providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act ("ERISA")*, *29 U.S.C. §1001 et seq*., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If

you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Plan Sponsors?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Plan Sponsor is that of employer and employee, Dependent or other classification as defined in the Plan.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participants and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Participants

All statements made by the Plan Sponsor or by a Participant shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you

receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card if you have any questions.

Does the Claims Administrator Receive Rebates and Other Payments?

The Plan Sponsor and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. The Plan Sponsor and the Claims Administrator do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD*, the *Schedule of Benefits* and any *Summary Material Modifications (SMM)*, and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Sponsor may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that the Plan Sponsor does so in any particular case shall not in any way be deemed to require the Plan Sponsor to do so in other similar cases.

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

What is the Future of the Plan?

Although Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or *Employee Retirement Income Security Act of 1974 (ERISA)*, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment or SMM. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan's next anniversary date, except as otherwise permitted by law.
- SMMs to the Plan are effective on the date the Plan Sponsor specifies.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Claims Administrator may use or disclose your information is found in the Claims Administrator *Notice of Privacy Practices.*

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. UnitedHealthcare agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to the Claims Administrator *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, the Claims Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan Sponsor's Plan is the secondary payer as described in *Section 7: Coordination of Benefits,* the Claims Administrator will process the Plan Sponsors payment of Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Sponsor's Plan is the secondary payer, the Claims Administrator will process the Plan Sponsor's payment of any Benefits available to you under the Plan as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect

include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile Plan - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plans discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

If the Plan pays Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to the Plan if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The *SPD*, the *Schedule of Benefits*, and any SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

Addendum - any attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Allowed Amounts - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator as shown in the *Schedule of Benefits*.

Allowed Amounts are determined solely in accordance with the Claims Administrator reimbursement policy guidelines. The Claims Administrator develops these guidelines, as the Claims Administrator determines, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Plan.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

Coinsurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness and Substance-Related and Addictive Disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:
    - "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
    - "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations.*

Covered Person - the Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Dependent – An eligible Dependent is considered to be:

- Your legal Spouse by marriage, Domestic Partner as defined in *Section 9: Defined Terms* or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- You and/or your Spouse’s, Domestic Partner’s or civil union partner’s biological children under the age of 26.

- Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.
- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that the Claims Administrator has identified as Designated Providers. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio and video technology.

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.

- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other’s sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and supporting documents. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- The Claims Administrator may, as the Claims Administrator determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and
    - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;

- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medicaid - a federal program administered and operated individually by participating state and territorial governments. The program provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator.

The Claims Administrator develops and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical*

Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator's PDL Management Committee.
- December 31st of the following calendar year.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Sponsor sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Care Service by a Physician.

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration* (*FDA*). This list is subject, from time to time, to the Claims Administrator's review and change. You may find out which tier a particular Pharmaceutical Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the Plan Sponsor's Self-Funded group health benefit plan.

The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, placing Pharmaceutical Products into specific tiers.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Plan.

Shared Savings Program - a program in which the Claims Administrator may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Coinsurance and any applicable deductible would still apply to the reduced charge. Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by the Claims Administrator. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by the Claims Administrator. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by the Claims Administrator.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this *SPD.* Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health care services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is

sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Amendment: Wellness

This Amendment to the Plan is issued by the Plan Sponsor as described below.

Because this Amendment is part of a legal document, the Plan wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Plan has defined these words in the *Summary Plan Description* in *Section 9: Defined Terms*.

What is the Wellness Amendment?

This Amendment describes the health and wellness tool that applies digital experiences, tools, games and rewards designed to engage Covered Persons in managing their health.

Who Is Eligible?

Participation is available to Covered Persons age 13 years and older; however, wellness rewards are only available to Covered Persons age 18 years and older.

What Are the Wellness Opportunities?

The health and wellness tool includes a wide range of wellness engagement opportunities. Engagement opportunities include the following:

- Interactive social media and games, which may include taking part in wellness challenges and health communities.
- *Health Survey*.
- *Online Personal Health Record*.
- An *Invite* to create personal missions.
- Integration with a variety of wellness devices (for example, wearable wireless trackers and mobile tools).

What Are the Rewards?

Covered Persons, age 18 years and older, receive wellness rewards for taking part in health and wellness opportunities as described above. When you take part in a health and wellness opportunity, you earn "coins" as a reward. For example, you may earn 40 coins for completing a *Health Survey*. You can save up coins and use the coins to enter into sweepstakes.

If you cannot meet a standard for a certain wellness reward, then you might qualify to earn the same reward by different means. You may call the Claims Administrator at the telephone number listed on your identification (ID) card who will work with you (and, if needed, with your doctor) to find another way for you to earn the same reward.

Clinical Programs and Resources

Care Management

Care Management Solutions

Standard Care Coordination

The Claims Administrator provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Care Coordination℠ program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Care Coordination℠ nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care Coordination℠ nurse to confirm that medications, needed equipment, or follow-up services are in place. The nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care Coordination℠ nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Complex Medical Conditions, Programs and Services

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

The Claims Administrator provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on the back of your ID card.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Care Service under the Plan.

Kidney Disease Programs

Kidney Resource Services program (KRS) program

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Travel and Lodging Assistance Program

Your Plan Sponsor is providing you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Allowed Amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Allowed Amount for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Facility.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Decision Support

NurseLine[SM]

NurseLine[SM] is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that Plan Sponsor has available that may help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine[SM] gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine[SM] is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLine[SM] any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.
    - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Wellness Management/Preventive Care

HealtheNotes℠

The Claims Administrator provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

The Claims Administrator provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in *Section 9: Defined Terms* under the definition of Covered Health Care Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information the Claims Administrator provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get educational information and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services

Neonatal Resource Services (NRS) is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

When you enroll in this program, the Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Provider's participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under the Covered Health Care Service Category.

Consumer Solutions and Self-Service Tools

Plan Sponsor believes in giving you tools to help you be an educated health care consumer. To that end, Plan Sponsor has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your

own health. The Claims Administrator and the Plan Sponsor are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. www.myuhc.com opens the door to a wealth of health information and self-service tools.

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM].
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Survey

You and your Spouse are invited to learn more about health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to www.myuhc.com. logging in, access your personalized Health & Wellness page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Outpatient Prescription Drug Schedule of Benefits

United Healthcare Services, Inc.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Copayment and/or Coinsurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. Supply limits are subject, from time to time, to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee. The reason for obtaining prior authorization from the Claims Administrator is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

The Plan may also require you to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee so the Claims Administrator can determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Claims Administrator's review and change. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you can ask the Claims Administrator to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Claims Administrator as described in this *Summary Plan Description (SPD)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and the Claims Administrator determines that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

The Claims Administrator may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Outpatient Prescription Drug Plan are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

The Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under this Outpatient Prescription Drug Plan will be included in calculating any Out-of-Pocket Limit stated in this *SPD*:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Special Programs:** The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, the Claims Administrator may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** The Claims Administrator may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	**What Is the Amount You Pay?** **This May Include a Copayment, Coinsurance or Both**	**Description and Supply Limits**
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	Specialty Prescription Drug Product: $100 per Prescription Order or Refill up to 31 days. Specialty Prescription Drug Product: $250 per Prescription Order or Refill up to 90 days.	The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at Network

Outpatient Prescription Drug Benefits	**What Is the Amount You Pay?** **This May Include a Copayment, Coinsurance or Both**	**Description and Supply Limits**
		Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	For a Tier 1 Prescription Drug Product: $10 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $50 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $50 of the Prescription Drug Charge per Prescription Order or Refill.	• A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For a Tier 1 Prescription Drug Product: $25 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $87.50 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $125 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $125 of the Prescription Drug Charge per Prescription Order or Refill.	When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. To maximize your Benefit, ask your Physician to write your Prescription Order or

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
		Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Outpatient Prescription Drug Plan

United Healthcare Services, Inc.

This portion of the Plan provides Benefits for Prescription Drug Products.

Because this section is part of a legal document, the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Claims Administrator has defined these words in either the *Summary Plan Description (SPD)* in *Section 9: Defined Terms* or in this Plan in *Outpatient Prescription Drug Defined Terms*.

When the Plan Sponsor uses the words "you" and "your" the Plan Sponsor is referring to people who are Covered Persons, as the term is defined in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in this *SPD* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Outpatient Prescription Drug Plan. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *SPD*.

Introduction Outpatient Prescription Drug Plan

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

The Claims Administrator may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Plan as described in this *SPD* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

When Does the Claims Administrator Limit Selection of Pharmacies?

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will choose a Network Pharmacy for you.

Rebates and Other Payments

The Claims Administrator and Pinnacol Assurance may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by the Claims Administrator, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

The Claims Administrator, and a number of the Claims Administrator's affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Plan*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Plan*. The Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, the Claims Administrator may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, the Claims Administrator may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy but do not inform the Claims Administrator, no Benefit will be paid.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products

are subject to Benefit enhancement, reduction or no Benefit by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid.

Please see *Outpatient Prescription Drug Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy supply limits apply.

Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Outpatient Prescription Drug Plan Exclusions

Exclusions from coverage listed in this *SPD* also apply to this Outpatient Prescription Drug Plan. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided under the medical Benefits portion of the Plan in this *SPD*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in this *SPD*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
13. Certain unit dose packaging or repackagers of Prescription Drug Products.
14. Medications used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Prescription Drug Products when prescribed to treat infertility.
18. Certain Prescription Drug Products for tobacco cessation.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Claims Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Certain Prescription Drug Products that have not been prescribed by a Specialist.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.
29. Dental products, including but not limited to prescription fluoride topicals.
30. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

31. Diagnostic kits and products.

32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

33. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Outpatient Prescription Drug Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by the Claims Administrator.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by the Claims Administrator.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator PDL Management Committee.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting the Claims Administrator at **myuhc.com** or the telephone number on your ID card.

Prescription Drug Charge - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to the Claims Administrator's review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Outpatient Prescription Drug Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Federal Notice

Language Assistance Services

The Claims Administrator provides free language services to help you communicate with us. The Claims Administrator offers interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. The Claims Administrator is available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

(Khmer) 1-866-633-2446.

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

The Claims Administrator[1] does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "The Claims Administrator" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

Any Health Risk Assessment (HRA) completed by a person covered by this plan is in compliance with regulations under GINA.

Medicaid and the Children's Health Insurance Program (CHIP) Free or Low Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility.

GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092

CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/ MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

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

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

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Summary Plan Description (SPD)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the plan is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the plan is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

    If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or *UnitedHealthcare* for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call the Claims Administrator at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from the Claims Administrator will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call the Claims Administrator at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, the Claims Fiduciary will review its decision. The Claims Fiduciary will also send you its written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, the Claims Fiduciary will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call the Claims Administrator at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact the Claims Administrator at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for grandfathered and non-grandfathered large group Plans that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Care Services under the Plan must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that

coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, the Claims Administrator will send you written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of the Claims Administrator's decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information (PHI). Protected Health Information is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider and identifies you or provides a means by which you could be identified. The Plan and the Plan Sponsor will not use or disclose PHI except for treatment, payment, health plan operations (collectively known as "TPO"), or as permitted or required by other state and federal law, or to Business Associates to help administer the Plan.

Further, the Plan Sponsor will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.
In addition, under the federal security regulations enacted pursuant to HIPAA, your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information (ePHI). ePHI is PHI that is maintained or transmitted in electronic form. The Plan and the Plan Sponsor will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.
The Plan and Plan Sponsor are separate and independent legal entities, which exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, the Plan Sponsor agrees to, and has certified to the Plan, that it will:

- Restrict the use or further disclosure of PHI except as permitted by HIPAA or as required by law;
- Ensure that any other entity to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- Not use genetic information that is PHI for underwriting purposes;
- Report to the Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- Make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures as required by law;
- Make internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- Provide adequate safeguards to protect PHI;
- Provide legally required notices of unauthorized acquisition, access or disclosures of your health information as required by law; and
- If feasible, upon termination of the plan, 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, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

In order to receive ePHI from the Plan, the Plan Sponsor agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in the Plan document is supported by reasonable and appropriate security measures; and
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information

Only limited members of the workforce of the Group Health Plan may be permitted to use and/or disclose PHI. Under this Plan the following individuals are permitted to have access to, use and/or disclose PHI:

- Employees of the Plan Sponsor who perform administrative services on behalf of the Plan, including payment, health care operations, design and administration. This includes County Administrator, Director of Human Resources, Benefits Manager, Benefits Administrator, Human Resources Specialists.
- Employees of the Plan Sponsor who have access to PHI for purposes of its use by the Employer in performing services for the Plan, including procurement of insurance, financial transactions and accounting. This includes Director of Finance, Administrative Coordinators, Payroll Accountants, Payroll Technicians, General Accounting Managers, Budget Managers and Budget Analysts.
- Service providers to the Plan. This includes County Attorneys, Benefit Consultants, Third Party Administrators, and IT Personnel.

The Plan will limit the use, disclosure or request for PHI to the minimum amount that is reasonably necessary to fulfill a request as set forth in this Agreement. Requests for disclosures other than by legal authority or by the participant will be reviewed by the Privacy Officer or his/her designee.

Where PHI is used or disclosed for the purposes of the Plan's own payment activity, whether through a TPA or Carrier, the employees of the Plan are permitted to use and disclose information to perform these functions using the minimum necessary to accomplish the purpose.
If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.
You may receive a complete copy of the Plan's Notice of Privacy Practices by contacting the Privacy Officer.

PRIVACY OFFICER
The Plan Administrator has designated a privacy officer who is the contact person for all issues regarding your privacy rights. You may contact the privacy officer at the following address and telephone number.

Director of Human Resources
4430 S. Adams County Parkway, Suite C4000B.
Brighton, CO 80601
phone: 720.523.6070
fax: 720.523.6069

HEALTH INSURANCE MARKETPLACE NOTIFICATION

General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health insurance, the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes (pre-tax premiums). Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This Plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” This Plan does meet the minimum value standard for the benefits it provides**.**

Administrative Statement

If the Plan is not subject to *ERISA*, the following information applies to you.

Claims Fiduciary: The Claims Administrator is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan. The Claims Fiduciary shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Fiduciary shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: Your Plan is self-funded. The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Fiduciary. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor has selected a provider Network established by UnitedHealthcare Insurance Company

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343
952-936-1300

Person designated as Agent for Service of Legal Process: Adams County Government

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Amendment to the Unum Group Life and Disability Insurance Policies
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: October 15, 2019
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approve Amendment No. 4 to the Unum Group Disability Insurance Policy effective January 1, 2020 and Amendment No.8 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Insurance Policy effective January 1, 2020 as approved through Study Session and Amendment No. 9 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Insurance Policy effective June 1, 2020.

BACKGROUND: The Board of County Commissioners previously entered into a contract with Unum Life Insurance Company of America ("Unum"), to provide a Life and Disability Group Insurance Policy for all benefit-eligible employees.

The attached Amendment No. 4 to the Unum Group Disability Insurance Policy amends the contract to change the eligibility rules and increase the maximum monthly long-term disability benefit from 60% up to $5,000 per month to 60% up to $9,000 per month providing additional income replacement for high income earners effective January 1, 2020 as approved through study session.

The attached Amendment No. 8 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Policy amends the contract to change the eligibility rules effective January 1, 2020 as approved through study session.

The attached Amendment No. 9 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Policy amends the contract to include guarantee issue life insurance coverage for employees and dependents who incur a life changing event during the plan year, effective June 1, 2020.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

People and Culture Services
County Manager's Office
Budget Office
County Attorney's Office

ATTACHED DOCUMENTS:
Amendment No. 4 to the Unum Group Disability Insurance Policy effective January 1, 2020
Amendment No. 8 to the Unum Group Life ADD Insurance Policy effective January 1, 2020
Amendment No. 9 to the Unum Group Life ADD Insurance Policy effective June 1, 2020
Unum Group Contract Rate Sheet updated January 1, 2019

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8622

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION ADOPTING AMENDMENT NO. 4 TO THE UNUM GROUP DISABILITY INSURANCE POLICY AND AMENDMENT NO. 8 AND AMENDMENT NO. 9 TO THE UNUM GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (ADD) POLICY

WHEREAS, the Board of County Commissioners previously entered into a contract with Unum Life Insurance Company of America ("Unum"), to provide a Life and Disability Group Insurance Policy for all benefit-eligible employees; and

WHEREAS, the attached Amendment No. 4 to the Unum Group Disability Insurance Policy amends the contract to change the eligibility rules and increase the maximum monthly long-term disability benefit from 60% up to $5,000 per month to 60% up to $9,000 per month providing additional income replacement for high income earners effective January 1, 2020 as approved through study session; and,

WHEREAS, the attached Amendment No. 8 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Policy amends the contract to change the eligibility rules effective January 1, 2020 as approved through study session; and,

WHEREAS, the attached Amendment No. 9 to the Unum Group Life and Accidental Death and Dismemberment (ADD) Policy amends the contract to include guarantee issue life insurance coverage for employees and dependents who incur a life changing event during the plan year, effective June 1, 2020.

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Amendments to Adams County's contracts with Unum Life Insurance Company of America.

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

AMENDMENT NO. 4

This amendment forms a part of Group Policy No. 420696 002 issued to the Policyholder:

Adams County

The entire policy is replaced by the policy attached to this amendment.

The effective date of these changes is January 1, 2020. The changes only apply to disabilities which start on or after the effective date.

The policy's terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on August 10, 2020.

Unum Life Insurance Company of America

By _____

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of August 10, 2020.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Adams County

By _____
Signature and Title of Officer

APPROVED AS TO FORM
COUNTY ATTORNEY

_____

unum

GROUP INSURANCE POLICY
NON-PARTICIPATING

POLICYHOLDER: Adams County

POLICY NUMBER: 420696 002

POLICY EFFECTIVE DATE: January 1, 2016

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Colorado

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

POLICY NUMBER: 420696 002

ELIGIBLE CLASS(ES):

All Full-Time and Part-Time Employees excluding Project Designated, Temporary, Seasonal, or Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 or more hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

For disability due to an injury

The latest of:

- 14 days for disability due to an injury; or
- the date your accumulated sick leave payments end, if applicable.

For disability due to a sickness

The latest of:

- 14 days for disability due to a sickness; or
- the date your accumulated sick leave or parental leave payments end, if applicable.

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

60% of weekly earnings to a maximum benefit of $1,200 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

MAXIMUM PERIOD OF PAYMENT:

11 weeks

Premium payments are required for your coverage while you are receiving payments under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $250 per week.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

OTHER FEATURES:

Minimum Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

POLICY NUMBER: 420696 002

ELIGIBLE CLASS(ES):

All Full-Time and Part-Time Employees excluding Project Designated, Temporary, Seasonal, or Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 or more hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

The later of:

- 90 days; or
- the date your accumulated sick leave payments end, if applicable.

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $9,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months

Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Continuity of Coverage

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your weekly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum weekly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us from your Employer.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation or of any other gainful occupation for which you are reasonably fitted by education, training, or experience;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us from your Employer.

POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

SHORT TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

Premium payments are required for an insured while he or she is receiving Short Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

LONG TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

WAIVER OF PREMIUM

Unum does not require premium payments for an insured while he or she is receiving Long Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Policyholder** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible class;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible class as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 45 day **grace period**.

If Unum cancels or modifies this policy or a plan for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the policyholder's Human Resource policy on family and medical leaves of absence if premium payments continue and the policyholder approved the employee's leave in writing.

Coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If the policyholder's Human Resource policy doesn't provide for continuation of an employee's coverage during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing conditions exclusion; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR SHORT TERM DISABILITY:

NAME/LOCATION (CITY AND STATE)

None

FOR LONG TERM DISABILITY:

NAME/LOCATION (CITY AND STATE)

None

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible class, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

Your Employer pays 100% of the cost of your coverage under a plan. You will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

For Short Term Disability:
If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 90 days following the date your temporary layoff begins.

If you are on a **leave of absence** other than a parental leave of absence, and if premium is paid, you will be covered for up to 90 days following the date your leave of absence begins.

If you are on a parental leave of absence, and if premium is paid, you will be covered for up to 6 weeks following the date your parental leave of absence begins.

For Long Term Disability:
If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 90 days following the date your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 90 days following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible class;
- the date your eligible class is no longer covered; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

Except as preempted by federal law, if your claim is denied in whole or in part and you have exhausted your administrative remedies under the policy/plan, you have the right to have your claim newly reviewed in any court with jurisdiction and to a trial by jury, if such rights are mandated by state law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

If you have a Cesarean section, you will be considered disabled for a minimum period of 8 weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the 8 weeks.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is the later of:

- 14 days; or
- the date your accumulated sick leave payments end, if applicable.

If your disability is the result of a sickness, your elimination period is the later of:

- 14 days; or
- the date your accumulated sick leave or parental leave payments end, if applicable.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your weekly earnings by 60%.
2. The maximum **weekly benefit** is $1,200.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

WHAT ARE YOUR WEEKLY EARNINGS?

"Weekly Earnings" means your gross weekly income from your Employer including shift differential and car allowance, in effect just prior to the date of disability. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457 (b) deferred compensation arrangement). Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the weekly payment if you are disabled and your weekly **disability earnings**, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from week to week, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 weeks.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

2. The amount that you receive:

   - under the mandatory portion of any "no fault" motor vehicle **plan**.
   - under a **salary continuation** plan.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

Unum will only subtract deductible sources of income which are payable as a result of the same disability.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(a) and 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: $25.

Unum may apply this amount toward an outstanding overpayment.

However, the minimum weekly payment will not be paid if you are receiving salary continuation or accumulated sick leave payments from your Employer.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each week up to the **maximum period of payment.** Your maximum period of payment is 11 weeks during a continuous period of disability.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries while sane.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

   If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.

SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your disability as continuous if your disability stops for 45 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is the later of:

- 90 days; or
- the date your **accumulated sick leave** payments end, if applicable.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $9,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

"Monthly Earnings" means your gross monthly income from your Employer including shift differential and car allowance, in effect just prior to the date of disability. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457 (b) deferred compensation arrangement). Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, we will subtract 50% of your disability earnings from your monthly payment.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments after your disability began under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - are entitled to receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any

eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

8. The amount that you receive under a **salary continuation** plan.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 62 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(a) and 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months

1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** is 24 months. Only 24 months of benefits will be paid even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you have received payments, Unum will send payments during the length of the confinement.

Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries while sane.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

ARE INCREASES IN COVERAGE SUBJECT TO A PRE-EXISTING CONDITION?

Your plan will not provide a maximum monthly benefit in excess of $5,000 which becomes effective on January 1, 2020 for any disability caused by, contributed to by, or resulting from the following pre-existing condition.

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to January 1, 2020; and
- the disability begins in the first 12 months after January 1, 2020.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 6 months of your gross disability payment if, on the date of your death:

- your disability had continued for 90 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 6 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 6 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 6 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Class(es) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Project designated, temporary, seasonal and contract workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar

retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

- For Short Term Disability:

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

- For Long Term Disability:

MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

- For Short Term Disability:

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

- For Long Term Disability:

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

- For Short Term Disability:

For disability due to an injury

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

For disability due to a sickness

SALARY CONTINUATION, ACCUMULATED SICK LEAVE OR PARENTAL LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation, accumulated sick leave or parental leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

- For Long Term Disability:

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your lawful spouse, if living; otherwise your children under age 25 equally.

"Spouse" wherever used includes:

- your civil union partner as established under Colorado law; or
- your partner in a civil union, registered domestic partnership or substantially similar legal relationship created in another jurisdiction.

TOTAL COVERED PAYROLL means the total amount of monthly earnings for which employees are insured under this plan.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

WEEKLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means an employee who is eligible for Unum coverage.

Additional Claim and Appeal Information
Relative to policy issued by Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at colorado.lhiga.com, email jkelldorf@gmail.com or contact:

Colorado Life and Health Insurance Protection Association
P. O. Box 36009
Denver, Colorado 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

AMENDMENT NO. 8

This amendment forms a part of Group Identification No. 420696 001 issued to the Employer/Applicant:

Adams County

The entire Summary of Benefits is replaced by the Summary of Benefits attached to this amendment.

The effective date of these changes is January 1, 2020. The changes only apply to deaths and covered losses that occur and disabilities which start on or after the effective date.

The Summary of Benefits' terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on August 14, 2020.

Unum Life Insurance Company of America

By _____

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of August 14, 2020.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Adams County

By _____
Signature and Title of Officer

APPROVED AS TO FORM
COUNTY ATTORNEY

_____

unum

GROUP INSURANCE
SUMMARY OF BENEFITS
NON-PARTICIPATING

IDENTIFICATION NUMBER: 420696 001

EFFECTIVE DATE OF COVERAGE: January 1, 2016

ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Maine

Unum Life Insurance Company of America
insures the lives of

Adams County

under the
Select Group Insurance Trust
Policy No. 292000

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this Summary of Benefits. Unum makes this promise subject to all of this Summary of Benefits' provisions.

The Employer should read this Summary of Benefits carefully and contact Unum promptly with any questions. This Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Signed for Unum at Portland, Maine on the Effective Date of Coverage.

President Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 420696 001

ELIGIBLE CLASS(ES):

All Full-Time Members, Elected Officials and Part-Time Employees excluding Project Designated, Temporary, Seasonal and Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:

Basic Benefit:

Your Employer pays the cost of your coverage.

Additional Benefit:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

BASIC BENEFIT

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1, to a maximum of $300,000

ADDITIONAL BENEFIT OPTIONS:

Option A

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1

Option B

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 2

Option C

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 3

Option D

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 4

Option E

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 5

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

2 x annual earnings

Evidence of Insurability **is not required** for amounts of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability **is required** for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$10,000

MAXIMUM BENEFIT OF BASIC LIFE INSURANCE FOR YOU:

$300,000

MAXIMUM BENEFIT OF ADDITIONAL LIFE INSURANCE FOR YOU:

$300,000

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Option A

$5,000

Option B

$10,000

Option C

$25,000

Option D

$50,000

Option E

$75,000

Option F

$100,000

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE'S INSURANCE OVER:

$25,000

Evidence of Insurability **is not required** for amounts of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability **is required** for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

Children:

Option A

Live birth to 14 days: $5,000
14 days to 6 months: $5,000
6 months through the end of the month in which your child reaches age 19 or through the end of the month in which your child reaches age 24 if a full-time student: $5,000

Option B

Live birth to 14 days: $10,000
14 days to 6 months: $10,000
6 months through the end of the month in which your child reaches

age 19 or through the end of the month in which your child reaches age 24 if a full-time student: $10,000

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 100% OF YOUR AMOUNT OF LIFE INSURANCE.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 420696 001

ELIGIBLE CLASS(ES):

All Full-Time Members, Elected Officials and Part-Time Employees excluding Project Designated, Temporary, Seasonal and Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Basic Benefit:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

BASIC BENEFIT

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1, to a maximum of $300,000

MINIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

$10,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

COMMON CARRIER BENEFIT

Maximum Benefit: The Full Amount

The Common Carrier Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Common Carrier benefit your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

CHILD CARE BENEFIT

Each Qualified Child

Annual Benefit Amount:

Birth through age 13

The lesser of:

- 5% of the Full Amount of your accidental death and dismemberment insurance; or

- $3,000

Maximum Benefit Amount:

$12,000

Maximum Benefit Period:

4 consecutive years

If, at the time of your death, you have no Qualified Child eligible for the Child Care Benefit, we will pay 5% of the Full Amount to a maximum benefit of $2,000 to you, your beneficiary or your authorized representative.

The Child Care Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Child Care Benefit, your accidental death benefit must be paid first.

This benefit will only be paid once per accident, even if you suffer an injury in the same accident

FELONIOUS ASSAULT BENEFIT FOR YOU

Benefit Amount:

10% of the Full Amount of your accidental death and dismemberment insurance benefit

Maximum Benefit Amount:

$10,000

The Felonious Assault Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order to receive the Felonious Assault Benefit, your accidental death and dismemberment must be paid first.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This $2,000 payment made in good faith satisfies Unum's legal duty to the extent of that $2,000 payment and Unum will not have to make that payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

HOW WILL UNUM MAKE PAYMENTS?

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This $2,000 payment made in good faith satisfies Unum's legal duty to the extent of that $2,000 payment and Unum will not have to make that payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Child Care Benefit will be paid to you, your spouse, your beneficiary or your or your spouse's authorized representative.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

EMPLOYER PROVISIONS

WHAT DOES THIS SUMMARY OF BENEFITS CONSIST OF FOR THE EMPLOYER?

This Summary of Benefits consists of:

- all Summary of Benefits' provisions and any amendments and/or attachments issued;
- the Employer's Participation Agreement;
- each employee's application for insurance (employee retains his own copy); and
- the certificate of coverage issued for each employee of the Employer.

This Summary of Benefits may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this Summary of Benefits. No other person, including an agent, may change this Summary of Benefits or waive any part of it.

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

PREMIUM WAIVER

Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 180 days. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

Also, Unum does not require premium payments for dependents when Unum approves an insured employee's claim for premium waiver of life insurance. Unum does not require further premium payments for dependents during the period the life insurance premium is waived.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS SUMMARY OF BENEFITS?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Employer** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during an insurance month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE EMPLOYER?

The Employer must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Employer records that, in Unum's opinion, have a bearing on this Summary of Benefits will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS SUMMARY OF BENEFITS OR A PLAN UNDER THIS SUMMARY OF BENEFITS?

This Summary of Benefits or a plan under this Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify this Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a basic benefit plan; or
- the number of employees insured for all additional benefits is less than 15 lives or 25% of those eligible, whichever is greater; or
- the number of employees insured under a plan decreases by 25%; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 15 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of this Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible class; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible class as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 45 day **grace period**.

If Unum cancels or modifies this Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel this Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify this Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel this Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, this Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels this Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this Summary of Benefits or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS SUMMARY OF BENEFITS WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR LIFE INSURANCE:

NAME/LOCATION (CITY AND STATE)

None

FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

NAME/LOCATION (CITY AND STATE)

None

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible class, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

This plan provides different additional life benefit options in addition to the basic life benefit and the basic accidental death and dismemberment benefit. When you first become eligible for coverage, you may apply for any additional life benefit option, however, you cannot be covered under more than one option at a time.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

Your Employer pays 100% of the cost of your coverage under the basic benefit. You will automatically be covered under the basic benefit at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

You pay 100% of the cost yourself for any additional life benefit option. You will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU APPLY FOR ADDITIONAL BENEFITS IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE? (LATE ENTRANTS)

You can apply for additional benefits within 31 days of a **change in status**. Evidence of insurability is required for any amount of insurance.

Coverage applied for due to a change in status will begin at 12:01 a.m. on the date Unum approves your evidence of insurability form.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER ADDITIONAL BENEFIT OPTION? (This does not apply to Late Entrants)

You can change your coverage by applying for a different additional life benefit option anytime during the plan year.

You can decrease or increase your coverage any number of levels.

Evidence of insurability is required if you increase your coverage by any level.

If you are not approved for the increase in your coverage, you will automatically remain at the same amount you had prior to applying for the increase.

A change in coverage that is made at anytime during the plan year will begin at 12:01 a.m. on the later of:

- the date you apply for the change in coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

An evidence of insurability form can be obtained from your Employer.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment.

An evidence of insurability form can be obtained from your Employer.

WHEN CAN YOU CANCEL YOUR ADDITIONAL COVERAGE?

You can cancel your additional coverage at anytime during the plan year. Any cancellation in coverage will take effect immediately, but will not affect a **payable claim** that occurs prior to the cancellation.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 90 days following the date your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 90 days following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date your eligible class is no longer covered; or
- the latest of:
  - the date you no longer are in an eligible class;
  - the last day of the period for which you made any required contributions; or
  - the end of the month in which you no longer are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect coverage for yourself or are insured under the plan, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

"Spouse" wherever used includes:

- your civil union partner as established under Colorado law; or
- your partner in a civil union, registered domestic partnership or substantially similar legal relationship created in another jurisdiction.

- Your unmarried children from live birth through the end of the month in which they reach age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children from the end of the month in which they reach age 19 through the end of the month in which they reach age 24, also are eligible if they are full-time students at an **accredited school**.

- Your unmarried dependent children who became **handicapped** prior to the end of the month in which they reach age 19.

- Your unmarried dependent children who became handicapped prior to the end of the month in which they reached age 24, while they were full-time students.

  Unum must receive proof within 31 days of the date the child is eligible for coverage under this Summary of Benefits, and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

Children include your own natural offspring, lawfully adopted children, stepchildren and children for whom you have legal guardianship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

WHEN DOES YOUR DEPENDENT COVERAGE BEGIN?

This plan provides different benefit options for your dependents. When your dependents become eligible for coverage, you may apply for any dependent option. However, your dependents cannot be covered under more than one option at a time.

Evidence of insurability is required if you are applying for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

You pay 100% of the cost yourself for any dependent option. Your dependents will be covered at 12:01 a.m. on the later of:

- the date your dependents are eligible for coverage, if you apply for insurance on or before that date or within 31 days after your dependents eligibility date; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU APPLY FOR DEPENDENT COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR DEPENDENTS' ELIGIBILITY DATE?

You can apply for dependent coverage within 31 days of a **change in status**. Evidence of insurability is required for any amount of insurance.

Dependent coverage applied for due to a change in status will begin at 12:01 a.m. on the date Unum approves your dependent's evidence of insurability form.

WHEN CAN YOU CHANGE YOUR DEPENDENT COVERAGE BY CHOOSING ANOTHER OPTION? (This does not apply to Late Entrants)

You can change your dependent coverage by applying for a different benefit option anytime during the plan year.

You can decrease or increase your dependent coverage any number of levels.

Evidence of insurability is required if you increase your dependent spouse coverage by any level.

A change in coverage that is made at anytime during the plan year will begin at 12:01 a.m. on the later of:

- the date you apply for the change in coverage; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

An evidence of insurability form for your dependents can be obtained from your Employer.

WHEN CAN YOU CANCEL YOUR DEPENDENT COVERAGE?

You can cancel your dependent coverage at anytime during the plan year. Any cancellation in dependent coverage will take effect immediately, but will not affect a **payable claim** that occurs prior to the cancellation.

WHAT IF YOUR DEPENDENT IS TOTALLY DISABLED ON THE DATE YOUR DEPENDENT'S COVERAGE WOULD NORMALLY BEGIN?

If your eligible dependent is **totally disabled**, your dependent's coverage will begin on the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR DEPENDENT'S COVERAGE END?

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date your eligible class is no longer covered; or
- the latest of:
  - the date you no longer are in an eligible class;
  - the date of your death;
  - the last day of the period for which you made any required contributions; or
  - the end of the month in which you no longer are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment;
- for a civil union, registered domestic partnership or similar legal relationship, the date of dissolution.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

WILL COVERAGE CONTINUE FOR A HANDICAPPED CHILD INSURED UNDER THE PLAN AFTER THE END OF THE MONTH IN WHICH THEY REACH AGE 19 OR IF A FULL-TIME STUDENT AGE 24?

Coverage will continue for a child age 24 who is handicapped, provided:

- the child is currently insured under the plan; and
- the child is unmarried; and
- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the end of the month in which the child reaches age 19 or if a full-time student, age 24 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT'S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, including shift differential and car allowance, in effect just prior to the date of loss. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement), Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your **elimination period**.

Your elimination period is 180 days.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 70; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 90 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy

again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 90 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE NINETY DAY CONVERSION APPLICATION PERIOD

If you or your dependents die within the 90 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350

1-800-343-5406

WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 50% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 12 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 12 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Class(es) in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life plans combined,

whichever is less.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible class if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and your dependents and pay the first premium within 90 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Class(es) in this plan.

Your dependents must apply for portable coverage and pay the first premium within 90 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of

insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

ADDING PORTABLE COVERAGE FOR DEPENDENTS

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Quadriplegia	The Full Amount
Triplegia	Three Quarters The Full Amount

Paraplegia	Three Quarters The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Hemiplegia	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount
Uniplegia	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, including shift differential and car allowance, in effect just prior to the date of loss. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement), Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and

• within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a **qualified child**; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:

- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT COMMON CARRIER BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you die from an accidental bodily injury received in an accident which is not an **occupational injury** and occurs while you are riding as a passenger in a common public passenger carrier.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT CHILD CARE BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative on behalf of each of your qualified children an annual benefit amount for child care if:

- you die:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child.

This benefit will only be paid once per accident, even if you suffer an injury in the same accident.

The annual benefit amount, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE CHILD CARE BENEFIT END FOR EACH QUALIFIED CHILD?

The child care benefit will terminate for each qualified child on the earliest of the following dates:

- the date you, your spouse or your or your spouse's authorized representative fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT FELONIOUS ASSAULT BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you sustain a loss which is caused directly by a felonious act of violence. The felonious act of violence must occur while you are working for your Employer, at your Employer's usual place of business, at an alternative work site at the direction of the Employer, including your home, or a location to which your job requires you to travel.

A felonious act of violence means an act that is considered a felony where the act occurred. The benefit is not payable if the loss occurred while you were committing a felonious act.

Felonious acts of violence include, but are not limited to: robbery, theft, hijacking, assault and battery, sniping, murder or civil disturbance.

Also, the loss must occur while you are insured under the plan.

The benefit amount and maximum benefit amount are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.

- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Class(es) in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 90 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Class(es) in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

ACCREDITED SCHOOL means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Class(es) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Project designated, temporary, seasonal and contract workers are excluded from coverage.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HANDICAPPED means permanently and continuously incapable of self sustaining support by reason of mental or physical incapacity.

HEMIPLEGIA means total and irreversible paralysis of both limbs on either side of the body (i.e. the right arm and right leg or the left arm and left leg).

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- **for purposes of Portability**, a bodily injury that is the direct result of an accident and not related to any other cause.
- **for all other purposes**, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIFE INSURANCE BENEFIT means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

OCCUPATIONAL INJURY means an injury that was caused by or aggravated by any employment for pay or profit or otherwise occurring within the course of employment.

PARAPLEGIA means total and irreversible paralysis of both lower limbs.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUADRIPLEGIA means total and irreversible paralysis of all four limbs.

QUALIFIED CHILD means:

- **for purposes of the Education Benefit**, any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

  - enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
  - at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

- **for purposes of the Child Care Benefit**, any of your unmarried dependent children under age 14 who, were enrolled in a licensed day care facility, school facility, or other similar program for 90 continuous days before the date of the accident causing your death. The Child Care Benefit will not be extended to any of your children born after the date of your death unless pregnancy commenced prior to the date of your death.

Children include your own natural offspring, lawfully adopted children, stepchildren and children for whom you have legal guardianship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

TRIPLEGIA means total and irreversible paralysis of three limbs.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

UNIPLEGIA means total and irreversible paralysis of one limb.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible class before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for **ACTIVE EMPLOYMENT** in the **GLOSSARY** section is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** (Accelerated Benefit) in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

Additional Claim and Appeal Information
Relative to the Summary of Benefits issued by
Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Summary of Benefits, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt

of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the

Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or summary of benefits and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or summary of benefits conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at colorado.lhiga.com, email jkelldorf@gmail.com or contact:

Colorado Life and Health Insurance Protection Association
P. O. Box 36009
Denver, Colorado 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

AMENDMENT NO. 9

This amendment forms a part of Group Identification No. 420696 001 issued to the Employer/Applicant:

Adams County

The entire Summary of Benefits is replaced by the Summary of Benefits attached to this amendment.

The effective date of these changes is June 1, 2020. The changes only apply to deaths and covered losses that occur and disabilities which start on or after the effective date.

The Summary of Benefits' terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on August 12, 2020.

Unum Life Insurance Company of America

By _____

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of August 12, 2020.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Adams County

By _____
Signature and Title of Officer

APPROVED AS TO FORM
COUNTY ATTORNEY

_____

unum

GROUP INSURANCE
SUMMARY OF BENEFITS
NON-PARTICIPATING

IDENTIFICATION NUMBER: 420696 001

EFFECTIVE DATE OF COVERAGE: January 1, 2016

ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Maine

Unum Life Insurance Company of America
insures the lives of

Adams County

under the
Select Group Insurance Trust
Policy No. 292000

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this Summary of Benefits. Unum makes this promise subject to all of this Summary of Benefits' provisions.

The Employer should read this Summary of Benefits carefully and contact Unum promptly with any questions. This Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Signed for Unum at Portland, Maine on the Effective Date of Coverage.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 420696 001

ELIGIBLE CLASS(ES):

All Full-Time Members, Elected Officials and Part-Time Employees excluding Project Designated, Temporary, Seasonal and Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:

Basic Benefit:

Your Employer pays the cost of your coverage.

Additional Benefit:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

BASIC BENEFIT

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1, to a maximum of $300,000

ADDITIONAL BENEFIT OPTIONS:

Option A

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1

Option B

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 2

Option C

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 3

Option D

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 4

Option E

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 5

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

2 x annual earnings

Evidence of Insurability **is not required** for amounts of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability **is required** for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$10,000

MAXIMUM BENEFIT OF BASIC LIFE INSURANCE FOR YOU:

$300,000

MAXIMUM BENEFIT OF ADDITIONAL LIFE INSURANCE FOR YOU:

$300,000

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Option A

$5,000

Option B

$10,000

Option C

$25,000

Option D

$50,000

Option E

$75,000

Option F

$100,000

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE'S INSURANCE OVER:

$25,000

Evidence of Insurability **is not required** for amounts of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability **is required** for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

Children:

Option A

Live birth to 14 days: $5,000
14 days to 6 months: $5,000
6 months through the end of the month in which your child reaches age 19 or through the end of the month in which your child reaches age 24 if a full-time student: $5,000

Option B

Live birth to 14 days: $10,000
14 days to 6 months: $10,000
6 months through the end of the month in which your child reaches age 19 or through the end of the month in which your child reaches age 24 if a full-time student: $10,000

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 100% OF YOUR AMOUNT OF LIFE INSURANCE.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 420696 001

ELIGIBLE CLASS(ES):

All Full-Time Members, Elected Officials and Part-Time Employees excluding Project Designated, Temporary, Seasonal and Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Basic Benefit:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

BASIC BENEFIT

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1, to a maximum of $300,000

MINIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

$10,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

COMMON CARRIER BENEFIT

Maximum Benefit: The Full Amount

The Common Carrier Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Common Carrier benefit your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

CHILD CARE BENEFIT

Each Qualified Child

Annual Benefit Amount:

Birth through age 13

The lesser of:

- 5% of the Full Amount of your accidental death and dismemberment insurance; or

- $3,000

Maximum Benefit Amount:

$12,000

Maximum Benefit Period:

4 consecutive years

If, at the time of your death, you have no Qualified Child eligible for the Child Care Benefit, we will pay 5% of the Full Amount to a maximum benefit of $2,000 to you, your spouse, your beneficiary or your authorized representative.

The Child Care Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Child Care Benefit, your accidental death benefit must be paid first.

This benefit will only be paid once per accident, even if you suffer an injury in the same accident

FELONIOUS ASSAULT BENEFIT FOR YOU

Benefit Amount:

10% of the Full Amount of your accidental death and dismemberment insurance benefit

Maximum Benefit Amount:

$10,000

The Felonious Assault Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order to receive the Felonious Assault Benefit, your accidental death and dismemberment must be paid first.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This $2,000 payment made in good faith satisfies Unum's legal duty to the extent of that $2,000 payment and Unum will not have to make that payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

HOW WILL UNUM MAKE PAYMENTS?

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This $2,000 payment made in good faith satisfies Unum's legal duty to the extent of that $2,000 payment and Unum will not have to make that payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Child Care Benefit will be paid to you, your spouse, your beneficiary or your or your spouse's authorized representative.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

EMPLOYER PROVISIONS

WHAT DOES THIS SUMMARY OF BENEFITS CONSIST OF FOR THE EMPLOYER?

This Summary of Benefits consists of:

- all Summary of Benefits' provisions and any amendments and/or attachments issued;
- the Employer's Participation Agreement;
- each employee's application for insurance (employee retains his own copy); and
- the certificate of coverage issued for each employee of the Employer.

This Summary of Benefits may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this Summary of Benefits. No other person, including an agent, may change this Summary of Benefits or waive any part of it.

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

PREMIUM WAIVER

Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 180 days. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

Also, Unum does not require premium payments for dependents when Unum approves an insured employee's claim for premium waiver of life insurance. Unum does not require further premium payments for dependents during the period the life insurance premium is waived.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS SUMMARY OF BENEFITS?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Employer** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during an insurance month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE EMPLOYER?

The Employer must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Employer records that, in Unum's opinion, have a bearing on this Summary of Benefits will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS SUMMARY OF BENEFITS OR A PLAN UNDER THIS SUMMARY OF BENEFITS?

This Summary of Benefits or a plan under this Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify this Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a basic benefit plan; or
- the number of employees insured for all additional benefits is less than 15 lives or 25% of those eligible, whichever is greater; or
- the number of employees insured under a plan decreases by 25%; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 15 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of this Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible class; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible class as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 45 day **grace period**.

If Unum cancels or modifies this Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel this Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify this Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel this Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, this Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels this Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this Summary of Benefits or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS SUMMARY OF BENEFITS WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR LIFE INSURANCE:

NAME/LOCATION (CITY AND STATE)

None

FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

NAME/LOCATION (CITY AND STATE)

None

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible class, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

This plan provides different additional life benefit options in addition to the basic life benefit and the basic accidental death and dismemberment benefit. When you first become eligible for coverage, you may apply for any additional life benefit option, however, you cannot be covered under more than one option at a time.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

Your Employer pays 100% of the cost of your coverage under the basic benefit. You will automatically be covered under the basic benefit at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

You pay 100% of the cost yourself for any additional life benefit option. You will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU APPLY FOR ADDITIONAL BENEFITS IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE? (LATE ENTRANTS)

You can apply for additional benefits within 31 days of a **change in status**. **Evidence of insurability** is required for any amount of life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

Coverage applied for due to a change in status will begin at 12:01 a.m. on the latest of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER ADDITIONAL BENEFIT OPTION? (This does not apply to Late Entrants)

You can change your coverage by applying for a different additional life benefit option anytime during the plan year.

You can decrease or increase your coverage any number of levels.

Evidence of insurability is required if you increase your coverage by any level.

If you are not approved for the increase in your coverage, you will automatically remain at the same amount you had prior to applying for the increase.

A change in coverage that is made at anytime during the plan year will begin at 12:01 a.m. on the later of:

- the date you apply for the change in coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

An evidence of insurability form can be obtained from your Employer.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment.

An evidence of insurability form can be obtained from your Employer.

WHEN CAN YOU CANCEL YOUR ADDITIONAL COVERAGE?

You can cancel your additional coverage at anytime during the plan year. Any cancellation in coverage will take effect immediately, but will not affect a **payable claim** that occurs prior to the cancellation.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 90 days following the date your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 90 days following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date your eligible class is no longer covered; or
- the latest of:
  - the date you no longer are in an eligible class;
  - the last day of the period for which you made any required contributions; or
  - the end of the month in which you no longer are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect coverage for yourself or are insured under the plan, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

  "Spouse" wherever used includes:

  - your civil union partner as established under Colorado law; or
  - your partner in a civil union, registered domestic partnership or substantially similar legal relationship created in another jurisdiction.

- Your unmarried children from live birth through the end of the month in which they reach age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children from the end of the month in which they reach age 19 through the end of the month in which they reach age 24, also are eligible if they are full-time students at an **accredited school**.

- Your unmarried dependent children who became **handicapped** prior to the end of the month in which they reach age 19.

- Your unmarried dependent children who became handicapped prior to the end of the month in which they reached age 24, while they were full-time students.

  Unum must receive proof within 31 days of the date the child is eligible for coverage under this Summary of Benefits, and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

Children include your own natural offspring, lawfully adopted children, stepchildren and children for whom you have legal guardianship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

WHEN DOES YOUR DEPENDENT COVERAGE BEGIN?

This plan provides different benefit options for your dependents. When your dependents become eligible for coverage, you may apply for any dependent option. However, your dependents cannot be covered under more than one option at a time.

Evidence of insurability is required if you are applying for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

You pay 100% of the cost yourself for any dependent option. Your dependents will be covered at 12:01 a.m. on the later of:

- the date your dependents are eligible for coverage, if you apply for insurance on or before that date or within 31 days after your dependents eligibility date; or

- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU APPLY FOR DEPENDENT COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR DEPENDENTS' ELIGIBILITY DATE?

You can apply for dependent coverage within 31 days of a **change in status**. Evidence of insurability is required if you are applying for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

Dependent coverage applied for due to a change in status will begin at 12:01 a.m. on the latest of:

- the date of the change in status, if you apply for dependent coverage on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU CHANGE YOUR DEPENDENT COVERAGE BY CHOOSING ANOTHER OPTION? (This does not apply to Late Entrants)

You can change your dependent coverage by applying for a different benefit option anytime during the plan year.

You can decrease or increase your dependent coverage any number of levels.

Evidence of insurability is required if you increase your dependent spouse coverage by any level.

A change in coverage that is made at anytime during the plan year will begin at 12:01 a.m. on the later of:

- the date you apply for the change in coverage; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

An evidence of insurability form for your dependents can be obtained from your Employer.

WHEN CAN YOU CANCEL YOUR DEPENDENT COVERAGE?

You can cancel your dependent coverage at anytime during the plan year. Any cancellation in dependent coverage will take effect immediately, but will not affect a **payable claim** that occurs prior to the cancellation.

WHAT IF YOUR DEPENDENT IS TOTALLY DISABLED ON THE DATE YOUR DEPENDENT'S COVERAGE WOULD NORMALLY BEGIN?

If your eligible dependent is **totally disabled**, your dependent's coverage will begin on the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR DEPENDENT'S COVERAGE END?

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date your eligible class is no longer covered; or
- the latest of:
  - the date you no longer are in an eligible class;
  - the date of your death;
  - the last day of the period for which you made any required contributions; or
  - the end of the month in which you no longer are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment;
- for a civil union, registered domestic partnership or similar legal relationship, the date of dissolution.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

WILL COVERAGE CONTINUE FOR A HANDICAPPED CHILD INSURED UNDER THE PLAN AFTER THE END OF THE MONTH IN WHICH THEY REACH AGE 19 OR IF A FULL-TIME STUDENT AGE 24?

Coverage will continue for a child age 24 who is handicapped, provided:

- the child is currently insured under the plan; and
- the child is unmarried; and

- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the end of the month in which the child reaches age 19 or if a full-time student, age 24 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT'S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, including shift differential and car allowance, in effect just prior to the date of loss. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement), Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your **elimination period**.

Your elimination period is 180 days.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 70; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 90 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy

again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 90 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE NINETY DAY CONVERSION APPLICATION PERIOD

If you or your dependents die within the 90 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350

1-800-343-5406

WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 50% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 12 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 12 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Class(es) in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life plans combined,

whichever is less.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible class if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and your dependents and pay the first premium within 90 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Class(es) in this plan.

Your dependents must apply for portable coverage and pay the first premium within 90 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of

insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

ADDING PORTABLE COVERAGE FOR DEPENDENTS

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Quadriplegia	The Full Amount
Triplegia	Three Quarters The Full Amount

Paraplegia	Three Quarters The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Hemiplegia	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount
Uniplegia	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, including shift differential and car allowance, in effect just prior to the date of loss. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement), Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and

• within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a **qualified child**; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:

- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT COMMON CARRIER BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you die from an accidental bodily injury received in an accident which is not an **occupational injury** and occurs while you are riding as a passenger in a common public passenger carrier.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT CHILD CARE BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative on behalf of each of your qualified children an annual benefit amount for child care if:

- you die:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child.

This benefit will only be paid once per accident, even if you suffer an injury in the same accident.

The annual benefit amount, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE CHILD CARE BENEFIT END FOR EACH QUALIFIED CHILD?

The child care benefit will terminate for each qualified child on the earliest of the following dates:

- the date you, your spouse or your or your spouse's authorized representative fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT FELONIOUS ASSAULT BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you sustain a loss which is caused directly by a felonious act of violence. The felonious act of violence must occur while you are working for your Employer, at your Employer's usual place of business, at an alternative work site at the direction of the Employer, including your home, or a location to which your job requires you to travel.

A felonious act of violence means an act that is considered a felony where the act occurred. The benefit is not payable if the loss occurred while you were committing a felonious act.

Felonious acts of violence include, but are not limited to: robbery, theft, hijacking, assault and battery, sniping, murder or civil disturbance.

Also, the loss must occur while you are insured under the plan.

The benefit amount and maximum benefit amount are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.

- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Class(es) in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 90 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Class(es) in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

ACCREDITED SCHOOL means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Class(es) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Project designated, temporary, seasonal and contract workers are excluded from coverage.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HANDICAPPED means permanently and continuously incapable of self sustaining support by reason of mental or physical incapacity.

HEMIPLEGIA means total and irreversible paralysis of both limbs on either side of the body (i.e. the right arm and right leg or the left arm and left leg).

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- **for purposes of Portability**, a bodily injury that is the direct result of an accident and not related to any other cause.
- **for all other purposes**, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIFE INSURANCE BENEFIT means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

OCCUPATIONAL INJURY means an injury that was caused by or aggravated by any employment for pay or profit or otherwise occurring within the course of employment.

PARAPLEGIA means total and irreversible paralysis of both lower limbs.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUADRIPLEGIA means total and irreversible paralysis of all four limbs.

QUALIFIED CHILD means:

- **for purposes of the Education Benefit**, any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:
  - enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
  - at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

- **for purposes of the Child Care Benefit**, any of your unmarried dependent children under age 14 who, were enrolled in a licensed day care facility, school facility, or other similar program for 90 continuous days before the date of the accident causing your death. The Child Care Benefit will not be extended to any of your children born after the date of your death unless pregnancy commenced prior to the date of your death.

Children include your own natural offspring, lawfully adopted children, stepchildren and children for whom you have legal guardianship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

TRIPLEGIA means total and irreversible paralysis of three limbs.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

UNIPLEGIA means total and irreversible paralysis of one limb.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible class before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for **ACTIVE EMPLOYMENT** in the **GLOSSARY** section is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** (Accelerated Benefit) in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

Additional Claim and Appeal Information
Relative to the Summary of Benefits issued by
Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Summary of Benefits, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt

of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the

Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or summary of benefits and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or summary of benefits conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION
We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

COVERAGE DECISIONS
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at colorado.lhiga.com, email jkelldorf@gmail.com or contact:

Colorado Life and Health Insurance Protection Association
P. O. Box 36009
Denver, Colorado 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

Adams County 2019 Rate Sheet

Policy Number 420696

Long Term Disability Rate:
$0.62 per $100 covered payroll

Short Term Disability Rate:
Effective 1/1/2019 to 3/31/2019: $0.28 per $10 weekly benefit
Effective 4/1/2019: $0.19 per $10 weekly benefit

Basic Life/AD&D Rates:
Life Rate: $0.10 per $1,000
AD&D Rate: $0.04 per $1,000

Buy-Up Life Rates:

Age Bands	Employee Life Rates per $1,000	Spouse Life Rates per $1,000	Child Life Rate per $1,000
0 – 24	$0.07	$0.07	$0.20
25 – 29	$0.07	$0.07	
30 – 34	$0.07	$0.07	
35 – 39	$0.10	$0.10	
40 – 44	$0.16	$0.16	
45 – 49	$0.29	$0.29	
50 – 54	$0.45	$0.45	
55 – 59	$0.76	$0.76	
60 – 64	$0.83	$0.83	
65 – 69	$1.43	$1.43	
70 – 74	$4.05	$4.05	
75+	$4.05	$4.05	

RESOLUTION 2020-480

A RESOLUTION CALLING AN ELECTION ON NOVEMBER 3, 2020 TO AUTHORIZE THE PERMANENT EXTENSION OF AN EXISTING COUNTYWIDE SALES TAX OF ONE-FOURTH OF ONE PERCENT (ONE-FOURTH PENNY PER DOLLAR) FOR THE CONTINUED PURPOSE OF PRESERVING OPEN SPACE AND CREATING AND MAINTAINING PARKS AND RECREATION FACILITIES; SETTING THE BALLOT TITLE AND TEXT FOR THE ELECTION; AND PROVIDING THE EFFECTIVE DATE OF SUCH RESOLUTION

WHEREAS, the Board of County Commissioners (the "Board") of Adams County, Colorado (the "County"), has determined that it is in the public interest and a priority of the residents of Adams County to protect water quality, wildlife areas, and wetlands; preserve farmland; protect open space to limit sprawl; and to create, improve and maintain parks, trails, and recreational facilities in Adams County; and,

WHEREAS, the Board has determined that there is and will be a deficiency in available funds to protect water quality, wildlife areas, and wetlands; preserve farmland; protect open space to limit sprawl; and to create, improve, and maintain parks, trails, and recreational facilities in Adams County for the foreseeable future; and,

WHEREAS, the County is authorized by law to impose a sales tax on the sale of tangible personal property at retail and the furnishing of services, subject to the approval of the registered electors of the County; and,

WHEREAS, in 1999, the voters of Adams County approved a one-fifth of one percent (one-fifth penny per dollar) countywide sales tax to preserve open space in order to limit sprawl, to preserve farmland, to protect wildlife areas, wetlands, rivers and streams, and for creating, improving, and maintaining parks and recreational facilities through 2006; and,

WHEREAS, in 2004 the voters of Adams County voted to increase the tax to one-fourth of one percent (one-fourth penny per dollar) to preserve land that protects water quality; protect wildlife areas, wetlands, rivers, and streams; preserve farmland; protect open space to limit sprawl; and for creating, improving, and maintaining parks, trails, and recreation facilities; and to extend the tax through 2026; and,

WHEREAS, the Board has determined that, as a result of the increase in growth in the County, the need to preserve open space has become increasingly urgent; and,

WHEREAS, the Board has therefore concluded that it is in the best interest of the residents of, and quality of life in, Adams County to permanently extend the existing one-fourth of one percent countywide sales tax (the "Open Space Sales Tax"), the receipts from which shall be restricted in application to the Open Space Program, as enumerated herein and in Resolutions 99-1 and 2004-01; and,

WHEREAS, the Board has determined that a ballot issue regarding a permanent extension of the Open Space Sales Tax for the purposes enunciated herein and in Resolutions 99-1 and 2004-01 should be submitted to the eligible electors of the County at the November 3, 2020 general election; and,

WHEREAS, the Board has determined to set the ballot title and text for the ballot issue to be submitted at the election called by this Resolution.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF ADAMS, STATE OF COLORADO:

1. An election shall be held on Tuesday, November 3, 2020, at which there shall be submitted to the eligible electors of the County a ballot issue authorizing a permanent extension of the Open Space Sales Tax originally imposed pursuant to Resolution No. 99-1, and increased and extended pursuant to Resolution No. 2004-01 (the "Open Space Sales Tax"), the title of which issue shall be in substantially the following form:

   ISSUE 1A

   WITH NO INCREASE IN ANY COUNTY TAX RATE, SHALL ADAMS COUNTY'S EXISTING OPEN SPACE SALES TAX OF ONE-FOURTH OF ONE PERCENT (ONE-FOURTH PENNY PER DOLLAR) BE PERMANENTLY EXTENDED WITH THE PROCEEDS TO CONTINUE TO BE USED SOLELY TO:

   PRESERVE LAND THAT PROTECTS WATER QUALITY;

   PROTECT WILDLIFE AREAS, WETLANDS, RIVERS, AND STREAMS;

   PRESERVE FARMLAND;

   PROTECT OPEN SPACE TO LIMIT SPRAWL; AND;

   FOR CREATING, IMPROVING, AND MAINTAINING PARKS, TRAILS, AND RECREATION FACILITIES; AND

   WITH ALL COUNTY EXPENDITURES TO BE ALLOCATED BETWEEN ACTIVE AND PASSIVE OPEN SPACE USES BASED ON THE RECOMMENDATIONS OF A CITIZEN ADVISORY COMMISSION AND SUBJECT TO AN ANNUAL AUDIT, WHICH TAX SHALL BE IMPOSED, COLLECTED, ADMINISTERED, AND ENFORCED AS PROVIDED IN RESOLUTION 2020-480 AND SHALL ALL REVENUES FROM SUCH TAX AND ANY EARNINGS THEREON, INCLUDING REVENUES SHARED WITH THE INCORPORATED CITIES AND TOWNS IN ADAMS COUNTY, FOR THE DURATION OF THE TAX, CONSTITUTE A VOTER-APPROVED REVENUE CHANGE FOR THE PURPOSES OF ARTICLE X, SECTION 20 OF THE COLORADO CONSTITUTION AND ANY OTHER REVENUE LIMITS IMPOSED BY THE LAWS OF THE STATE OF COLORADO?

   YES _____ NO _____

2. The election shall be conducted by the Adams County Clerk and Recorder ("Clerk and Recorder") in accordance with the Uniform Election Code, C.R.S. § 1-1-101, *et seq*., and other laws of the State of Colorado, including without limitation, the requirements of article X, section 20, of the Colorado Constitution (hereinafter "TABOR").

3. All acts required or permitted by the Uniform Election Code relevant to conducting this election shall be performed by the Clerk and Recorder.

4. The Clerk and Recorder shall cause all notices of election to be provided in accordance the laws of the State of Colorado, including but not limited to, the Uniform Election Code and TABOR.

5. Pursuant to C.R.S. § 29-2-104 (5), the Clerk and Recorder shall publish the text of this Resolution four separate times, a week apart, in the official newspaper of the County and each city and incorporated town within the County.

6. If a majority of the votes cast on the ballot issue of permanently extending the imposition of the Open Space Sales Tax are in favor of such ballot issue, the Open Space Sales Tax shall be permanently extended and shall apply to all taxable transactions, unless exempt, occurring on or after January 1, 2021, and shall be collected and administered in accordance with County Resolutions 99-1, 2004-01, and this Resolution and the schedules set forth in the rules and regulations promulgated by the Colorado Department of Revenue.

   (a) *Extension of the Imposition of the Sales Tax*. There is hereby permanently extended the imposition on all sales of tangible personal property at retail or the furnishing of services in the County, as provided in section 29-2-105, ***et. seq.,*** C.R.S., as amended, a tax equal to one-fourth of one percent of the gross receipts (the "Open Space Sales Tax").

   (b) *Transactions Subject to the Sales Tax*. The transaction subject to the Open Space Sales Tax shall be as set forth below and as required by Colorado state law.

      (i) The tangible personal property and services taxable hereunder shall be the same as the tangible personal property and services taxable pursuant to section 39-26-104, C.R.S., except as provided herein, and shall be subject to the same exemptions as those specified in part 7 of article 26 of title 39, C.R.S., expressly including the exemption allowed by section 39-26-709 (1), C.R.S., for purchases of machinery or machine tools, the exemption for sales of electricity, coal, wood, gas, fuel oil, or coke specified in section 39-26-715 (1)(a)(II), C.R.S., the exemption for sales of food specified in section 39-26-707 (1)(e), C.R.S., the exemption for vending machine sales of food set forth in section 39-26-714 (2), C.R.S., the exemption for occasional sales by a charitable

organization set forth in section 39-26-718 (1)(b), C.R.S., the exemption for sales and purchases of farm equipment and farm equipment under lease or contract specified in section 39-26-716 (1)(d), (2)(b) and (2)(c), C.R.S., and the exemption for sales of low-emitting motor vehicles, power sources, or parts used for converting such power sources as specified in section 39-26-719 (1), C.R.S. Also expressly exempted are pesticides that are registered by the commissioner of agriculture for use in the production of agricultural and livestock products pursuant to the provisions of the "Pesticide Act," article 9 of title 35, C.R.S., and offered for sale by dealers licensed to sell such pesticides pursuant to section 35-9-115, C.R.S., all sales and purchases of parts used in the repair or maintenance of farm equipment, all shipping pallets or aids paid for by a farm operation, and aircraft designed or adapted to undertake agricultural applications, and all sales and purchases of dairy equipment. Also expressly exempted are the exemption for sales of machinery or machine tools specified in section 39-26-709 (1), C.R.S., used in the processing of recovered materials by a business listed in the inventory prepared by the department of public health and environment pursuant to section 30-20-122 (1)(a)(V), C.R.S.; the exemption for sales of wood from salvaged trees killed or infested in Colorado by mountain pine beetles or spruce beetles as specified in section 39-26-723, C.R.S.; the exemption for sales of components used in the production of energy, including but not limited to alternating current electricity, from a renewable energy source specified in section 39-26-724, C.R.S.; the exemption for sales that benefit a Colorado school specified in section 39-26-725, C.R.S.; the exemption for sales by an association or organization of parents and teachers of public school students that is a charitable organization as specified in section 39-26-718 (1)(c), C.R.S.; the exemption for sales of property for use in space flight specified in section 39-26-728, C.R.S.; and the exemption for manufactured homes set forth in section 39-26-721 (3).

(ii) The Sales Tax shall not be imposed on the sale of construction and building materials, as the term is used in section 29-2-109, C.R.S., if the purchaser of such materials presents to the retailer a building permit or other acceptable documentation that a local use tax has been paid or is required to be paid on the value thereof.

(iii) The Sales Tax shall not be imposed on the sale of personal property on which a specific ownership tax has been paid or is payable if: (I) the purchaser is a nonresident of or has its principal place of business

outside the County, and (II) such personal property is registered or required to be registered outside the limits of the County under the laws of the State of Colorado.

(iv) The Sales Tax shall not be imposed on the sale of tangible personal property at retail or the furnishing of services if the transaction has been previously subjected to a sales or use tax lawfully imposed on the purchaser or user by another statutory or home rule county equal to or in excess of the amount imposed by Section 6 (a) hereof. A credit shall be granted against the Sales Tax payable with respect to such transaction equal in amount to the lawfully imposed sales or use tax previously paid by the purchaser or user to such other statutory or home rule county, provided that such credit shall not exceed the amount of the Sales Tax imposed by Section 6 (a) hereof.

(c) *Determination of Place at Which Sales are Consummated*. For the purpose of this Resolution, all retail sales are sourced as specified in section 39-26-104 (3), C.R.S. The amount subject to the Sales Tax shall not include the amount of any state sales and use tax imposed by article 26 of title 39, C.R.S.

(d) *Collection, Administration and Enforcement.* The collection, administration and enforcement of the Sales Tax shall be performed by the Executive Director of the Colorado Department of Revenue (the "Executive Director") in the same manner as the collection, administration and enforcement of the Colorado state sales tax. The provisions of article 26 of title 39, C.R.S. and all rules and regulations promulgated thereunder by the Executive Director shall govern the collection, administration, and enforcement of the Sales Tax.

(e) *Vendor Fee.* No vendor fee shall be permitted or withheld with respect to the collection and remittance of the Sales Tax.

7. Distribution of Sales Tax Revenue. The proceeds from the collection of the Open Space Sales Tax shall be administered and distributed in the following manner:

(a) *Open Space Advisory Board.* The Open Space Advisory Board shall continue to be appointed by the Board of County Commissioners.

(i) The Open Space Advisory Board shall consist of seven members, four of whom shall be residents of unincorporated Adams County and three of whom shall be residents of cities or towns located in Adams County.

(ii) Members shall serve four-year terms of office, except the initial term of two members from the unincorporated area of Adams County and two members from cities and towns were six years. Members may be re-appointed to successive terms.

(iii) Members shall serve at the pleasure of the Board.

(iv) The Board of County Commissioners shall develop a system to rotate the jurisdictions represented on the Open Space Advisory Board in a systematic fashion.

(v) Members shall not be compensated for their services, but they may be reimbursed for reasonable expenses actually incurred in the performance of their duties in accordance with this Resolution and County policy.

(vi) Members shall act in accordance with law, including Colorado conflict of interest law applicable to public bodies. No member shall vote or participate in the application process regarding an acquisition or expenditure in which he or she has a financial or ownership interest, or where he or she has an ownership interest in adjacent property.

(vii) The Open Space Advisory Board will meet quarterly, or as necessary to review proposed projects. All meetings shall be held in accordance with Colorado Open Meetings Law.

(viii) The Open Space Advisory Board will make recommendations to the Board of County Commissioners regarding the distribution of proceeds from the collection of the Open Space Sales Tax, substantially in accordance with the guidelines set forth in this Resolution.

(b) *Deposit and Expenditure of Revenue.*

(i) The County has established an Open Space Fund within which all revenues and expenditures from the Open Space Sales Tax are accounted for.

(ii) Two percent (2%) of the Open Space Sales Tax collected shall continue to be used by the Open Space Advisory Board for administrative purposes, i.e. consultants, studies, site reviews, etc.

(iii) After payment of the administrative fee, thirty percent (30%) of the remaining Open Space Sales Tax collected shall continue to be automatically returned to the cities, towns and unincorporated area of Adams County in the same proportion as is the ratio of Open Space Sales Tax collected within the city, town or unincorporated area to the total County sales tax collections, as computed from information provided by the Colorado Department of Revenue.

This money may be used by the jurisdiction for either active or passive uses but shall not be used to augment existing parks and open space budgets.

(iv) After payment of the administrative expenses and distribution of the thirty percent described above, the moneys remaining in the Open Space Fund shall be used as directed by the Board of County Commissioners, substantially in accordance with the following guidelines:

(1) Grant applications may be submitted to the Open Space Advisory Board by those jurisdictions having an approved open space and/or recreation plan.

(2) The Open Space Advisory Board shall review the application and make recommendations to the Board of County Commissioners regarding approval or denial of the application. Fund distributions may be attributable to both active and passive open space uses, defined as:

(A) Passive open space uses include the purchase, construction and maintenance of: horse, bike or running trails; natural areas with limited development for fishing, hiking, walking or biking; wildlife preserves; lakes for fishing with accessible walks, docks, picnic areas and restrooms; conservation easements on agricultural land; environmental education programs; lands and waterways as community buffers; river and stream corridor land; unimproved flood plains; wetlands; preservation of cemeteries; and picnic facilities.

(B) Active uses include the purchase, construction, equipping and maintenance of: sports fields, golf courses, and recreation centers.

(v) Any funds received from the disposition of assets acquired or constructed with revenues of the Open Space Sales Tax shall be used in accordance with the above guidelines.

(c) *Authorized Projects and Uses of Funds.*

(i) Revenues collected from the Open Space Sales Tax may be used in the following manner:

(A) To acquire fee title interest in real property for open space, natural areas, wildlife habitat, agricultural and ranch lands, historical amenities, parks and trails;

(B) To acquire less than fee interests in real property such as easements (including conservation and agricultural), leases, options, future interests, covenants, development rights, subsurface rights and contractual rights, either on an exclusive or nonexclusive basis, for open space, natural areas, wildlife habitat, agricultural and ranch lands, historical amenities, parks and trails purposes;

(C) To acquire water rights and water storage rights for use in connection with the aforementioned purposes;

(D) To acquire rights-of-way and easements for trails and access to public lands, and to build and improve such trails and accessways;

(E) To allow expenditure of funds for joint projects between counties and municipalities, recreation districts, or other governmental entities in the County;

(F) To improve and protect open space, natural areas, wildlife habitats, agricultural and ranch lands, historical amenities, parks and trails;

(G) To manage, patrol and maintain open space, natural areas, wildlife habitats, agricultural and ranch lands, historical amenities, parks and trails;

(H) To pay for related acquisition, construction, equipment, operation and maintenance costs;

(I) To implement and effectuate the purposes of the Open Space Program.

(ii) Passive open space lands may be acquired and maintained and may include:

(A) Lands with significant natural resource, scenic and wildlife habitat values;

(B) Lands that are buffers maintaining community identity;

(C) Lands that are to be used for trails and/or wildlife migration routes;

(D) Lands that will be preserved for agricultural or ranch purposes;

(E) Lands for outdoor recreation purposes limited to passive recreational use, including but not limited to hiking, hunting, fishing, photography, nature studies, and if specifically designated, bicycling or horseback riding;

(F) Lands with other important values such as scenic and historic sites that contribute to the County's and County municipalities' natural and cultural heritage.

(iii) Active open space lands may include lands for park purposes and other recreational uses such as sports fields, golf courses and recreation centers. Park purposes shall be defined as the construction, equipping, acquisition and maintenance of park and recreational improvements and facilities for the use and benefit of the public.

(iv) No land or interests acquired with the revenues of the Open Space Sales Tax may be sold, leased, traded, or otherwise conveyed, nor may an exclusive license or permit on such land or interests be given, without the approval of such action by the Board.

8. If a majority of the votes cast on the ballot issue of permanently extending the Open Space Sales Tax are in favor of such issue, the Clerk and Recorder shall provide a notice of adoption of this Resolution, together with a certified copy of this Resolution, to the Executive Director of the Colorado Department of Revenue at least forty-five (45) days prior to January 1, 2021.

9. For the purpose of C.R.S. § 1-11-203.5, this Resolution shall serve to set the ballot title for the ballot question set forth herein, and the ballot title for such ballot question shall be the text of the ballot question itself.

10. The officers and employees of the County are hereby authorized and directed to take all action necessary or appropriate to effectuate the provisions of this Resolution.

11. The rate of the Sales Tax and the deposit of revenues collected from the Open Space Sales Tax as set forth in this Resolution shall not be amended, altered, or otherwise changed unless first submitted to a vote of the registered electors of the County for their approval or rejection. Other provisions of this Resolution may be amended as necessary to effectuate the purposes of this Resolution by resolution adopted by the Board of County Commissioners in accordance with law.

12. All actions not inconsistent with the provisions of this Resolution heretofore taken by the Board and the officers and employees of the County and directed toward holding the election for the purposes stated herein are hereby ratified, approved, and confirmed.

13. All prior acts, orders or resolutions, or parts thereof, by the County inconsistent or in conflict with this Resolution are hereby repealed to the extent only of such inconsistency or conflict.

14. If any section, paragraph, clause, or provision of this Resolution shall be adjudged to be invalid or unenforceable, the invalidity or unenforceability of such section, paragraph, clause, or provision shall not affect any of the remaining sections, paragraphs, clauses, or provisions of this Resolution, it being the intention that the various parts hereof are severable.

15. The cost of the election shall be paid from the County's general fund.

16. This Resolution shall take effect immediately upon its passage.

RESOLUTION 2020-481

A RESOLUTION CALLING AN ELECTION ON NOVEMBER 3, 2020 TO AUTHORIZE THE PERMANENT EXTENSION OF AN EXISTING COUNTYWIDE SALES TAX OF ONE-HALF OF ONE PERCENT (ONE-HALF PENNY PER DOLLAR) FOR THE CONTINUING PURPOSE OF IMPROVEMENTS TO OR THE BUILDING OF ROAD AND BRIDGE PROJECTS AND THE CONTINUING PURPOSE OF CONSTRUCTING, ACQUIRING, EQUIPPING, OPERATING, MAINTAINING AND EXPANDING EXISTING AND NEW ADAMS COUNTY GOVERNMENT FACILITIES; A PORTION OF WHICH TAX SHALL CONTINUE TO BE SHARED WITH THE INCORPORATED CITIES AND TOWNS IN ADAMS COUNTY; SETTING THE BALLOT TITLE AND TEXT OF THE BALLOT ISSUE FOR THE ELECTION; AND PROVIDING THE EFFECTIVE DATE OF SUCH RESOLUTION

WHEREAS, the Board of County Commissioners (the "Board") of Adams County, Colorado (the "County"), has determined that county transportation and county capital facilities are priorities to the residents of the County, and it is in the public interest to provide for improvements to or the building of road and bridge projects, and for constructing, acquiring, equipping, operating, maintaining, and expanding existing and new Adams County government facilities, to accommodate the continuing growth in population in the County; and,

WHEREAS, the Board has determined that there is and will be a deficiency in available funds for both the improvements to roadway infrastructure and constructing, acquiring, equipping, operating, maintaining, and expanding existing and new Adams County government facilities for the foreseeable future; and,

WHEREAS, there are not sufficient funds in the treasury of the County and the Board does not anticipate that existing sources of revenue will be sufficient to generate the moneys necessary for the desired improvements to or the building of road and bridge projects and existing and new Adams County government facilities; and,

WHEREAS, the County is authorized by law to impose a sales tax on the sale of tangible personal property at retail and the furnishing of services, subject to approval by a majority of the registered electors of the County voting thereon; and,

WHEREAS, in 1993 the voters of Adams County approved the one-half of one percent (one-half penny per dollar) sales tax for the construction of the Adams County Justice Center, the tax was extended in 1997 for the expansion of the Adams County Detention Facility, the tax was extended in 2001 to provide for the building of road and bridge projects, in 2006 the sales tax was extended to continue to provide for the building of road and bridge projects and for the construction of the Adams County Justice Center, a pre-trial holding facility and a centralized government center, and in 2014 the voters of Adams County authorized the sales tax to continue to provide for the building of road and bridge projects and to be used for constructing, acquiring, equipping, operating, maintaining, and expanding existing and new Adams County Government facilities; and,

WHEREAS, the Board has determined that the existing one-half of one percent countywide sales tax should be permanently extended, to provide the necessary funds to pay for the continuing purpose of improvements to or the building of road and bridge projects throughout the county and the continuing purpose of constructing, acquiring, equipping, operating, maintaining, and expanding existing and new Adams County government facilities; and,

WHEREAS, the Board has determined that a ballot issue regarding the permanent extension of the sales tax for the purposes enunciated herein should be submitted by the Board to the eligible electors of the County at the November 3, 2020 general election; and,

WHEREAS, the Board has determined to set the ballot title and ballot text for the ballot issue to be submitted at the election called by this Resolution.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF ADAMS, STATE OF COLORADO:

1. An election shall be held on Tuesday, November 3, 2020, at which there shall be submitted to the eligible electors of the County a ballot issue authorizing the permanent extension of the sales tax imposed pursuant to County Resolution No. 93-1, and temporarily extended pursuant to County Resolutions No. 97-1, 01-1, and 06-01, and amended by County Resolution 2014-319 (the "Sales Tax"), the title of which issue shall be in substantially the following form:

   ISSUE 1B

   WITH NO INCREASE IN ANY COUNTY TAX RATE, SHALL ADAMS COUNTY'S EXISTING ONE-HALF OF ONE PERCENT (ONE-HALF PENNY PER DOLLAR) SALES TAX BE PERMANENTLY EXTENDED FOR THE CONTINUED PURPOSE OF IMPROVEMENTS TO OR THE BUILDING OF ROAD AND BRIDGE PROJECTS AND THE CONTINUED PURPOSE OF CONSTRUCTING, ACQUIRING, EQUIPPING, OPERATING, MAINTAINING, AND EXPANDING EXISTING AND NEW ADAMS COUNTY GOVERNMENT FACILITIES, WITH SUCH TAX TO BE IMPOSED, COLLECTED, ADMINISTERED, AND ENFORCED AS PROVIDED IN RESOLUTION 2020-481, AND WITH FORTY (40) PERCENT OF THE REVENUES FROM SUCH TAX TO CONTINUE TO BE SHARED AMONG THE COUNTY AND THE INCORPORATED CITIES AND TOWNS IN THE COUNTY FOR IMPROVEMENTS TO OR THE BUILDING OF ROAD AND BRIDGE PROJECTS AND SIXTY (60) PERCENT OF THE REVENUES FROM SUCH TAX TO CONTINUE TO BE USED FOR EXISTING AND NEW ADAMS COUNTY GOVERNMENT FACILITIES AS PROVIDED IN RESOLUTION 2020-481, AND WITH ALL REVENUES FROM SUCH TAX AND ANY EARNINGS THEREON, INCLUDING SHARED REVENUES, FOR THE DURATION OF THE TAX, TO CONSTITUTE A VOTER-APPROVED REVENUE CHANGE FOR THE PURPOSES OF ARTICLE X, SECTION 20 OF

THE COLORADO CONSTITUTION AND ANY OTHER REVENUE LIMITS IMPOSED BY THE LAWS OF THE STATE OF COLORADO?

YES _____ NO_____

2. The election shall be conducted by the Adams County Clerk and Recorder ("Clerk and Recorder") in accordance with the Uniform Election Code, C.R.S. § 1-1-101, *et. seq*., and other laws and regulations of the State of Colorado, including without limitation, the requirements of article X, section 20 of the Colorado Constitution (hereinafter "TABOR").

3. All acts required or permitted by the Uniform Election Code relevant to conducting this election shall be performed by the Clerk and Recorder.

4. The Clerk and Recorder shall cause all notices of election to be provided in accordance with the laws of the State of Colorado, including but not limited to, the Uniform Election Code and TABOR.

5. Pursuant to C.R.S. § 29-2-104 (5), the Clerk and Recorder shall publish the text of this Resolution four separate times, a week apart, in the official newspaper of the County and each city and incorporated town within the County.

6. If a majority of the votes cast on the ballot issue of permanently extending the imposition of the Sales Tax are in favor of such ballot issue, the Sales Tax shall be permanently extended and shall apply to all taxable transactions, unless exempt, occurring on or after January 1, 2021, and shall be collected, administered and enforced in accordance with County Resolutions 93-1, 97-1, 01-1, 06-01, 2014-319, and this Resolution and the schedules set forth in the rules and regulations promulgated by the Colorado Department of Revenue.

   (a) *Extension of the Imposition of the Sales Tax*. There is hereby permanently extended the imposition on all sales of tangible personal property at retail or the furnishing of services in the County, as provided in section 29-2-105, *et. seq.,* C.R.S., as amended, a tax equal to one-half of one percent of the gross receipts (the "Sales Tax").

   (b) *Transactions Subject to the Sales Tax*. The transaction subject to the sales tax shall be as set forth below and as required by Colorado state law.

      (i) The tangible personal property and services taxable hereunder shall be the same as the tangible personal property and services taxable pursuant to section 39-26-104, C.R.S., except as provided herein, and shall be subject to the same exemptions as those specified in part 7 of article 26 of title 39, C.R.S., expressly including the exemption allowed by section 39-26-709 (1), C.R.S., for purchases of machinery or machine tools, the exemption for sales of

electricity, coal, wood, gas, fuel oil, or coke specified in section 39-26-715 (1)(a)(II), C.R.S., the exemption for sales of food specified in section 39-26-707 (1)(e), C.R.S., the exemption for vending machine sales of food set forth in section 39-26-714 (2), C.R.S., the exemption for occasional sales by a charitable organization set forth in section 39-26-718 (1)(b), C.R.S., the exemption for sales and purchases of farm equipment and farm equipment under lease or contract specified in sections 39-26-716 (1)(d), (2)(b) and (2)(c), C.R.S., and the exemption for sales of low-emitting motor vehicles, power sources, or parts used for converting such power sources as specified in section 39-26-719 (1), C.R.S. Also expressly exempted are pesticides that are registered by the commissioner of agriculture for use in the production of agricultural and livestock products pursuant to the provisions of the "Pesticide Act," article 9 of title 35, C.R.S., and offered for sale by dealers licensed to sell such pesticides pursuant to section 35-9-115, C.R.S., all sales and purchases of parts used in the repair or maintenance of farm equipment, all shipping pallets or aids paid for by a farm operation, and aircraft designed or adapted to undertake agricultural applications, and all sales and purchases of dairy equipment. Also expressly exempted are the exemption for sales of machinery or machine tools specified in section 39-26-709 (1), C.R.S., used in the processing of recovered materials by a business listed in the inventory prepared by the department of public health and environment pursuant to section 30-20-122 (1)(a)(V), C.R.S.; the exemption for sales of wood from salvaged trees killed or infested in Colorado by mountain pine beetles or spruce beetles as specified in section 39-26-723, C.R.S.; the exemption for sales of components used in the production of energy, including but not limited to alternating current electricity, from a renewable energy source specified in section 39-26-724, C.R.S.; the exemption for sales that benefit a Colorado school specified in section 39-26-725, C.R.S.; the exemption for sales by an association or organization of parents and teachers of public school students that is a charitable organization as specified in section 39-26-718 (1)(c), C.R.S.; the exemption for sales of property for use in space flight specified in section 39-26-728, C.R.S.; and the exemption for manufactured homes set forth in section 39-26-721 (3).

(ii) The Sales Tax shall not be imposed on the sale of construction and building materials, as the term is used in section 29-2-109, C.R.S., if the purchaser of such materials presents to the retailer a building permit or other acceptable documentation that a local use tax has been paid or is required to be paid on the value thereof.

(iii) The Sales Tax shall not be imposed on the sale of personal property on which a specific ownership tax has been paid or is payable if: (I) the purchaser is a nonresident of or has its principal place of business outside the County, and (II) such personal property is registered or required to be registered outside the limits of the County under the laws of the State of Colorado.

(iv) The Sales Tax shall not be imposed on the sale of tangible personal property at retail or the furnishing of services if the transaction has been previously subjected to a sales or use tax lawfully imposed on the purchaser or user by another statutory or home rule county equal to or in excess of the amount imposed by Section 6 (a) hereof. A credit shall be granted against the Sales Tax payable with respect to such transaction equal in amount to the lawfully imposed sales or use tax previously paid by the purchaser or user to such other statutory or home rule county, provided that such credit shall not exceed the amount of the Sales Tax imposed by Section 6 (a) hereof.

(c) *Determination of Place at Which Sales are Consummated*. For the purpose of this Resolution, all retail sales are sourced as specified in section 39-26-104 (3), C.R.S. The amount subject to the Sales Tax shall not include the amount of any state sales and use tax imposed by article 26 of title 39, C.R.S.

(d) *Collection, Administration and Enforcement.* The collection, administration and enforcement of the Sales Tax shall be performed by the Executive Director of the Colorado Department of Revenue (the "Executive Director") in the same manner as the collection, administration and enforcement of the Colorado state sales tax. The provisions of article 26 of title 39, C.R.S. and all rules and regulations promulgated thereunder by the Executive Director shall govern the collection, administration, and enforcement of the Sales Tax.

(e) *Vendor Fee.* No vendor fee shall be permitted or withheld with respect to the collection and remittance of the Sales Tax.

7. Distribution of Sales Tax Revenue. The proceeds from the collection of the Sales Tax shall be administered in the following manner:

(a) Forty percent (40%) of all revenue collected pursuant to this resolution shall be distributed as follows: unless otherwise requested by a city or town, the forty percent allocated under this subsection shall be automatically remitted to the cities, towns and the County in the same proportion as is the ratio of Sales Tax collected within the city, town or unincorporated area of the County to the total County Sales Tax collections, as computed from information provided by the Colorado Department of Revenue. The revenue from the Sales Tax must be used by the jurisdiction for improvements to or the building of road and bridge projects within the jurisdiction. If a city or town does not wish to accept its

proportional share of revenue from the Sales Tax, that Sales Tax revenue shall be allocated to the County and must be used by the County for improvements to or the building of road and bridge projects within the County. All revenue received by the County under this sub-section shall be deposited in the County's road and bridge fund, and all revenue and expenditures from the Sales Tax shall be accounted for.

(b) Sixty percent (60%) of all revenue collected pursuant to this resolution shall be used by Adams County for use on existing and new Adams County government facilities. No portion of the sixty percent allocated under this sub-section will be distributed to cities or towns. All revenue received under this sub-section shall be deposited in the County's Capital Facilities Fund, and all revenue and expenditures from the Sales Tax shall be accounted for.

8. If a majority of the votes cast on the issue of permanently extending the Sales Tax are in favor of such ballot issue, the County Clerk and Recorder shall provide a notice of adoption of this Resolution, together with a certified copy of this Resolution, to the Executive Director of the Colorado Department of Revenue at least forty-five (45) days prior to January 1, 2021.

9. For the purposes of C.R.S. § 1-11-203.5, this Resolution shall serve to set the ballot title for the ballot issue set forth herein, and the ballot title for such ballot issue shall be the text of the ballot issue itself.

10. The officers and employees of the County are hereby authorized and directed to take all action necessary or appropriate to effectuate the provisions of this Resolution.

11. The rate of the Sales Tax and the deposit of revenues collected from the Sales Tax as set forth in this Resolution shall not be amended, altered, or otherwise changed unless first submitted to a vote of the registered electors of the County for their approval or rejection. Other provisions of this Resolution may be amended as necessary to effectuate the purposes of this Resolution by resolution adopted by the Board of County Commissioners in accordance with law.

12. All actions not inconsistent with the provisions of this Resolution heretofore taken by the members of the Board and the officers and employees of the County and directed toward holding the election for the purposes stated herein are hereby ratified, approved and confirmed.

13. All prior acts, orders or resolutions, or parts thereof, by the County inconsistent or in conflict with this Resolution are hereby repealed to the extent only of such inconsistency or conflict.

14. If any section, paragraph, clause or provision of this Resolution shall be adjudged to be invalid or unenforceable, the invalidity or unenforceability of such section,

paragraph, clause or provision shall not affect any of the remaining sections, paragraphs, clauses or provisions of this Resolution, it being the intention that the various parts hereof are severable.

15. The cost of the election shall be paid from the County's general fund.

16. This Resolution shall take effect immediately upon its passage.

RESOLUTION 2020-482

A RESOLUTION REFERRING TO THE REGISTERED ELECTORS OF ADAMS COUNTY, AT THE NOVEMBER 3, 2020 GENERAL ELECTION, THE QUESTION OF WHETHER THE TERM LIMITS FOR THE OFFICE OF ADAMS COUNTY CORONER SHOULD BE ELIMINATED SO THAT THE CORONER IS ALLOWED TO SERVE THE RESIDENTS OF ADAMS COUNTY, FOR AS LONG AS THE VOTERS OF ADAMS COUNTY CHOOSE TO RE-ELECT HIM/HER, AS AUTHORIZED BY ARTICLE XVIII SECTION 11(2) OF THE COLORADO CONSTITUTION; SETTING THE BALLOT TITLE AND THE BALLOT TEXT OF THE BALLOT QUESTION FOR THE ELECTION; AND PROVIDING THE EFFECTIVE DATE OF SUCH RESOLUTION

WHEREAS, Pursuant to the Uniform Election Code, §§ 1-1-101, *et. seq.,* C.R.S., a general election will be held on November 3, 2020; and,

WHEREAS, the Board of County Commissioners intends to refer to the registered voters of Adams County, Colorado, at the November 3, 2020 general election, a ballot question that, if approved, would eliminate the term limits for the office of Adams County Coroner so that the Coroner would be allowed to serve the residents of Adams County, for as long as the voters of Adams County choose to re-elect him/her, as authorized by Article XVIII, Section 11(2), of the Colorado Constitution; and to set the ballot text and title for the ballot question to be submitted at the general election.

NOW, THEREFORE BE IT RESOLVED, BY THE BOARD OF COUNTY COMMISSIONERS, COUNTY OF ADAMS, STATE OF COLORADO:

1. Pursuant to §§1-1-111, 1-5-203(3), and 30-11-103.5, C.R.S., the Board of County Commissioners hereby authorizes and directs that the following ballot question be certified herewith to the Adams County Clerk and Recorder for submission to the registered electors of Adams County by inclusion on the ballot for the November 3, 2020 general election:

   Shall the term limits for the office of Adams County Coroner be eliminated so that the Coroner is allowed to serve the residents of Adams County, for as long as the voters of Adams County choose to re-elect him/her, as authorized by Article XVIII Section 11(2), of the Colorado Constitution?

   YES ____ NO____

2. Pursuant to § 1-1-110, C.R.S., the Clerk and Recorder is the chief election official for Adams County, and the Clerk and Recorder shall conduct the general election in accordance with the Uniform Election Code, § 1-1-101, *et. seq.,* C.R.S., and any other relevant laws or rules of the State of Colorado.

3. The Clerk and Recorder shall cause all notices of election to be published in accordance with the laws of the State of Colorado and shall perform all acts

necessary or appropriate to effectuate the provisions of this Resolution.

4. The officers and employees of the County are hereby authorized and directed to take all action necessary or appropriate to effectuate the provision of this Resolution.

5. All actions consistent with the provisions of this Resolution heretofore taken by the members of the Board of County Commissioners and the officers and employees of the County and directed toward holding the election for the purposes stated herein are hereby ratified, approved, and confirmed.

6. All prior acts, orders or resolutions, or parts thereof, by the County inconsistent or in conflict with this Resolution are hereby repealed to the extent only of such inconsistency or conflict.

7. If any section, paragraph, clause, or provision of this Resolution shall be adjudged to be invalid or unenforceable, the invalidity or unenforceability of such section, paragraph, clause, or provision shall not affect any of the remaining sections, paragraphs, clauses, or provisions of this Resolution, it being the intention that the various parts hereof are severable.

8. This Resolution shall serve to set the ballot title and the ballot text for the question set forth herein, and the ballot title for such question shall be the text of the question itself.

9. The cost of the election shall be paid from the County's general fund.

10. This Resolution shall take effect immediately upon its passage.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Resolution correcting the location for PRC2019-00013; McCarty and Heinz Acres.
FROM: Jill Jennings-Golich, Community & Economic Development Department Director
AGENCY/DEPARTMENT: Community and Economic Development Department
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves a resolution correcting the location for PRC2019-00013; McCarty and Heinz Acres.

BACKGROUND:
PRC2019-00013 McCarty and Heinz Acres was approved by the Board of County Commissioners on June 16, 2020, at the address of 12730 Brighton Rd. The associated Resolution Approving Application in Case #PRC2019-00013 McCarty and Heinz Acres was drafted and recorded by staff with an address at 12570 Brighton Rd. (see attached Recorded Resolution Approving Application in Case #PRC2019-00013 McCarty and Heinz Acres).

The revised resolution has since corrected those errors and included the correct address, as approved by the Board of County Commissioners on June 16, 2020 (see attached Resolution Correcting the Resolution Approving Application in Case #PRC2019-00013; McCarty and Heinz Acres). The revised resolution is intended to replace the incorrect version.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community and Economic Development
County Attorney

ATTACHED DOCUMENTS:

Recorded Resolution Approving Application in Case #PRC2019-00013; McCarty and Heinz Acres
Resolution Correcting the Resolution Approving of Application in Case #PRC2019-00013; McCarty and Heinz Acres

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION CORRECTING AND RESTATING THE RESOLUTION APPROVING OF APPLICATION IN CASE # PRC2019-00013 MCCARTY AND HEINZ ACRES

WHEREAS, this case involved requests for: a Minor Subdivision Final Plat to create two lots, a zoning map amendment to designate a property from Agricultural-2 to Agricultural-1, and a waiver from subdivision design standards to exceed the maximum lot depth-to-width ratio. All three requests are on the following described property:

LOCATION: 12730 Brighton Road (Parcel number 0157135000035)

LEGAL DESCRIPTION: THAT PART OF THE NORTHWEST QUARTER OF SECTION 35, TOWNSHIP 1 SOUTH, RANGE 67 WEST OF THE 6TH PRINCIPAL MERIDIAN, DESCRIBED AS FOLLOWS:

BEGINNING AT A POINT ON THE NORTH AND SOUTH CENTERLINE OF SECTION 35, WHICH IS 400 FEET SOUTH OF THE NORTH QUARTER CORNER OF SAID SECTION; THENCE WESTERLY AND PARALLEL WITH THE NORTH LINE OF SAID SECTION, 1204.7 FEET, MORE OR LESS, TO THE CENTERLINE OF COUNTY ROAD NO. 131 (BRIGHTON ROAD); THENCE SOUTHWESTERLY ALONG THE CENTERLINE OF SAID COUNTY ROAD, 387.7 FEET; THENCE EASTERLY AND PARALLEL WITH THE NORTH LINE OF SAID SECTION, 1400.9 FEET, MORE OR LESS, TO THE NORTH AND SOUTH CENTERLINE OF SAID SECTION; THENCE NORTHERLY ALONG THE NORTH AND SOUTH CENTERLINE OF SAID SECTION, 334.4 FEET TO THE TRUE POINT OF BEGINNING, EXCEPT THE PORTION OF SUBJECT PROPERTY LYING WITHIN BRIGHTON ROAD, COUNTY OF ADAMS, STATE OF COLORADO.

WHEREAS, the Adams County Planning Commission held a public hearing on the application on the 28th day of May, 2020, and forwarded a recommendation of APPROVAL to the Board of County Commissioners; and

WHEREAS, the Board of County Commissioners held a public hearing on the application on the 16th day of June, 2020; and

WHEREAS, the resolution approving the case contained an error in the Location; and

WHEREAS, the Community and Economic Development Department now wishes to amend that resolution to ensure that the correct address is reflected.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that based upon the evidence presented at the hearing and the recommendation of the Adams County Planning Commission, the application in this case is hereby APPROVED based upon the following findings-of-fact, conditions of approval, and notes to the applicant:

Findings-of-Fact:

1. The final plat is consistent and conforms to the approved sketch plat.
2. The final plat is in conformance with the subdivision design standards.

3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.
8. The final plat is consistent with the Adams County Comprehensive Plan and any available area plan.
9. The final plat is consistent with the purposes of these standards and regulations.
10. The overall density of development within the proposed subdivision conforms to the zone district density allowances.
11. The proposed subdivision is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County. The proposed subdivision has established an adequate level of compatibility by:
    a. Incorporating natural physical features into the development design and providing sufficient open spaces considering the type and intensity of use;
    b. Incorporating site planning techniques to foster the implementation of the County's plans, and encourage a land use pattern to support a balanced transportation system, including auto, bike and pedestrian traffic, public or mass transit, and the cost effective delivery of other services consistent with adopted plans, policies and regulations of the County;
    c. Incorporating physical design features in the subdivision to provide a transition between the project and adjacent land uses through the provision of an attractive entryway, edges along public streets, architectural design, and appropriate height and bulk restrictions on structures;
    d. Incorporating identified environmentally sensitive areas, including but not limited to, wetlands and wildlife corridors, into the project design; and
    e. Incorporating public facilities or infrastructure, or cash-in-lieu, reasonably related to the proposed subdivision so the proposed subdivision will not negatively impact the levels of service of the County services and facilities.
12. The Zoning Map amendment is consistent with the Adams County Comprehensive Plan.
13. The Zoning Map amendment is consistent with the purposes of these standards and regulations.

14. The Zoning Map amendment will comply with the requirements of these standards and regulations
15. The Zoning Map amendment is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
16. Extraordinary hardships or practical difficulties result from strict compliance with these standards and regulations.
17. The purpose of the standards and regulations are served to a greater extent by the alternative proposal.
18. The waiver does not have the effect of nullifying the purpose of these standards and regulations.

Note to the Applicant:

1. The applicant shall comply with all building, zoning, fire, engineering, and health codes and regulations during the development of the subject site.

Electronically Recorded RECEPTION#: 2020000055579,
6/18/2020 at 2:21 PM, 1 OF 3,

TD Pgs: 0 Josh Zygielbaum, Adams County, CO.

STATE OF COLORADO)
COUNTY OF ADAMS)

At a regular meeting of the Board of County Commissioners for Adams County, Colorado, held at the Government Center in Brighton, Colorado on the 16th day of June, 2020 there were present:

Eva J. Henry	**Commissioner**
Charles "Chaz" Tedesco	**Commissioner**
Emma Pinter	**Commissioner**
Steve O'Dorisio	**Commissioner**
Mary Hodge	**Commissioner**
Heidi Miller	**County Attorney**
Erica Hannah	**Clerk to the Board**

when the following proceedings, among others were held and done, to-wit:

RESOLUTION APPROVING APPLICATION IN CASE # PRC2019-00013 McCARTY AND HEINZ ACRES

Resolution 2020-363

WHEREAS, this case involved requests for: a Minor Subdivision Final Plat to create two lots, a zoning map amendment to designate a property from Agricultural-2 to Agricultural-1, and a waiver from subdivision design standards to exceed the maximum lot depth-to-width ratio. All three requests are on the following described property:

APPROXIMATE LOCATION: 12570 Brighton Road

LEGAL DESCRIPTION: THAT PART OF THE NORTHWEST QUARTER OF SECTION 35, TOWNSHIP 1 SOUTH, RANGE 67 WEST OF THE 6TH PRINCIPAL MERIDIAN, DESCRIBED AS FOLLOWS:

BEGINNING AT A POINT ON THE NORTH AND SOUTH CENTERLINE OF SECTION 35, WHICH IS 400 FEET SOUTH OF THE NORTH QUARTER CORNER OF SAID SECTION; THENCE WESTERLY AND PARALLEL WITH THE NORTH LINE OF SAID SECTION, 1204.7 FEET, MORE OR LESS, TO THE CENTERLINE OF COUNTY ROAD NO. 131 (BRIGHTON ROAD); THENCE SOUTHWESTERLY ALONG THE CENTERLINE OF SAID COUNTY ROAD, 387.7 FEET; THENCE EASTERLY AND PARALLEL WITH THE NORTH LINE OF SAID SECTION, 1400.9 FEET, MORE OR LESS, TO THE NORTH AND SOUTH CENTERLINE OF SAID SECTION; THENCE NORTHERLY ALONG THE NORTH AND SOUTH CENTERLINE OF SAID SECTION, 334.4 FEET TO THE TRUE POINT OF BEGINNING, EXCEPT THE PORTION OF SUBJECT PROPERTY LYING WITHIN BRIGHTON ROAD, COUNTY OF ADAMS, STATE OF COLORADO.

WHEREAS, the Adams County Planning Commission held a public hearing on the application on the 28th day of May, 2020, and forwarded a recommendation of APPROVAL to the Board of County Commissioners; and

WHEREAS, the Board of County Commissioners held a public hearing on the application on the 16th day of June, 2020; and

WHEREAS, substantial testimony was presented by members of the public and the applicant.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that based upon the evidence presented at the hearing, the application in this case is hereby APPROVED based upon the following findings-of-fact and note to the applicant:

Findings-of-Fact:

1. The final plat is consistent and conforms to the approved sketch plat.

2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.
8. The final plat is consistent with the Adams County Comprehensive Plan and any available area plan.
9. The final plat is consistent with the purposes of these standards and regulations.
10. The overall density of development within the proposed subdivision conforms to the zone district density allowances.
11. The proposed subdivision is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County. The proposed subdivision has established an adequate level of compatibility by:
    a. Incorporating natural physical features into the development design and providing sufficient open spaces considering the type and intensity of use;
    b. Incorporating site planning techniques to foster the implementation of the County's plans, and encourage a land use pattern to support a balanced transportation system, including auto, bike and pedestrian traffic, public or mass transit, and the cost effective delivery of other services consistent with adopted plans, policies and regulations of the County;
    c. Incorporating physical design features in the subdivision to provide a transition between the project and adjacent land uses through the provision of an attractive entryway, edges along public streets, architectural design, and appropriate height and bulk restrictions on structures;
    d. Incorporating identified environmentally sensitive areas, including but not limited to, wetlands and wildlife corridors, into the project design; and
    e. Incorporating public facilities or infrastructure, or cash-in-lieu, reasonably related to the proposed subdivision so the proposed subdivision will not negatively impact the levels of service of the County services and facilities.
12. The Zoning Map amendment is consistent with the Adams County Comprehensive Plan.
13. The Zoning Map amendment is consistent with the purposes of these standards and regulations.
14. The Zoning Map amendment will comply with the requirements of these standards and regulations
15. The Zoning Map amendment is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
16. Extraordinary hardships or practical difficulties result from strict compliance with these standards and regulations.
17. The purpose of the standards and regulations are served to a greater extent by the alternative proposal.
18. The waiver does not have the effect of nullifying the purpose of these standards and regulations.

Note to the Applicant:

1. The applicant shall comply with all building, zoning, fire, engineering, and health codes and regulations during the development of the subject site.

Electronically Recorded RECEPTION#: 2020000055579,
6/18/2020 at 2:21 PM, 3 OF 3,
TD Pgs: 0 Josh Zygielbaum, Adams County, CO.

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Henry_____Aye
Tedesco_____Aye
Pinter_____Aye
O'Dorisio_____Aye
Hodge_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Josh Zygielbaum, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 16th day of June A.D. 2020.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Josh Zygielbaum:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Intergovernmental Agreement with Southeast Weld Fire Protection District for distribution of CARES funds.
FROM: Alisha Reis, Deputy County Manager
AGENCY/DEPARTMENT: County Manager's Office/County Attorney's Office/Budget & Finance Department
HEARD AT STUDY SESSION ON: June 2, 2020
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the IGA to distribute CARES funds to Southeast Weld Fire Protection District.

BACKGROUND:

Attached is an intergovernmental agreement for the Board's consideration to distribute a portion of funding allocated to the County by the Coronavirus Aid, Relief, and Economic Security Act (CARES). The County was allocated about $90.3 million, and the Board of County Commissioners previously agreed to allocate $1 million to fire districts serving Adams County. The Board also approved a funding formula based upon population of Adams County residents living within the fire districts. The formula is included as part of the IGA as Exhibit A.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

County Manager's Office
County Attorney's Office
Budget & Finance Department

ATTACHED DOCUMENTS:

Resolution
Intergovernmental Agreement

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION APPROVING INTERGOVERNMENTAL AGREEMENT BETWEEN THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF ADAMS AND SOUTHEAST WELD FIRE PROTECTION DISTRICT REGARDING DISBURSEMENT OF CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ACT FUNDS

WHEREAS, Section 18(2) of Article XIV of the Colorado Constitution and Sections 29-1-201, *et seq.* and 29-20-105 of the Colorado Revised Statutes authorize and encourage governments to cooperate by contracting with one another for their mutual benefit; and,

WHEREAS, the COVID-19 pandemic has created myriad economic distress and unanticipated costs in American society to individuals and families, to businesses, and to the state and local governments addressing the pandemic's effects; and,

WHEREAS, Congress recently enacted the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 ("CARES") to provide relief funds to individuals, businesses, and state and local governments; and,

WHEREAS, CARES allows Adams County (the "County") to directly receive funds for costs incurred in fighting and ameliorating the effects of COVID-19; and,

WHEREAS, pursuant to the terms of this Agreement, the County wishes to disburse to the Southeast Weld Fire Protection District (the "District"), and the District wishes to receive from the County, CARES funds for COVID-19 related costs incurred by the District.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the Intergovernmental Agreement between the Board of County Commissioners of the County of Adams and Southeast Weld Fire Protection District regarding disbursement of Coronavirus Aid, Relief and Economic Security Act Funds, is hereby approved.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners is authorized to execute said Intergovernmental Agreement.

INTERGOVERNMENTAL AGREEMENT BETWEEN ADAMS COUNTY AND SOUTHEAST WELD FIRE PROTECTION DISTRICT REGARDING DISBURSEMENT OF CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ACT FUNDS

THIS INTERGOVERNMENTAL AGREEMENT ("Agreement"), is made this _____ day of July, 2020, by and between Adams County, Colorado, located at 4430 S. Adams County Parkway, Brighton, CO 80601 ("County") and Southeast Weld County Fire Protection District located at 95 W. Broadway St., Keenesburg, CO ("District") for the purpose of disbursing funds provided by the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 ("CARES").

WITNESSETH:

WHEREAS, Section 18(2) of Article XIV of the Colorado Constitution and Sections 29-1-201, *et seq.* and 29-20-105 of the Colorado Revised Statutes authorize and encourage governments to cooperate by contracting with one another for their mutual benefit; and,

WHEREAS, the COVID-19 pandemic has created myriad economic distress and unanticipated costs in American society to individuals and families, to businesses, and to the state and local governments addressing the pandemic's effects; and,

WHEREAS, Congress recently enacted CARES to provide relief funds to individuals, businesses, and state and local governments; and,

WHEREAS, CARES allows the County to directly receive funds for costs incurred in fighting and ameliorating the effects of COVID-19; and,

WHEREAS, pursuant to the terms of this Agreement, the County wishes to disburse to District, and District wishes to receive from County, CARES funds for COVID-19 related costs incurred by District.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

I. FUNDING

CARES funds are allocated based on the percentage of the population in a given state that resides in the jurisdiction requesting direct funding from the federal government. County is similarly allocating CARES funds based on the percentage of the County population residing in each fire district. The spreadsheet attached as Exhibit A, and incorporated herein, shows the amount of CARES funds available to each Adams County fire district.

County will disburse to District the funds allocated to District in Exhibit A in a single payment. The payment will be disbursed to District only after County receives an invoice from District for the payment. District understands and agrees that the County's obligation to disburse these CARES funds is expressly contingent upon the County receiving said funds from the federal government. In the event the federal government fails to remit said funds, or reduces said funds, the County may reduce or terminate its payment accordingly. No Adams County funds shall be encumbered or involved in this Agreement.

District must submit reports on the expenditure of its CARES funds, including the amount and purpose of each expenditure, to County monthly. Any CARES funds not spent by December 4, 2020, shall be returned to the County so that the County's obligation to return unspent CARES funds to the Federal Treasury may be timely fulfilled.

II. SCOPE OF PROJECT AND ACCOUNTING

CARES funds shall be spent solely for the COVID-19 related costs set forth in CARES. CARES imposes expenditure and accounting obligations upon local governments receiving CARES funds. District agrees to be solely responsible for ensuring that it spends and accounts for the CARES funds received from the County in strict compliance with CARES requirements. Because CARES is recent legislation, the parties anticipate that additional federal legislation, rules, and regulations may be promulgated regarding the expenditure and accounting requirements. District shall familiarize itself with, and shall adhere to, all current and subsequent legislation, rules, and regulations. In the event of non-compliance with its legislative and regulatory mandates, the federal government may seek reimbursement of funds it deems were not spent in compliance with its legislation and rules. In the event the federal government seeks reimbursement of funds spent by District, District shall be solely responsible for reimbursing said funds, and, in the event the federal government seeks reimbursement of funds spent by

District from County, District shall reimburse County for any funds returned by County on District's behalf within thirty days of County's reimbursement.

III. PUBLIC NECESSITY

The Parties agree that the work performed pursuant to this Agreement is necessary for the health, safety, comfort, convenience, and welfare of all the people in Adams County in the fight against COVID-19.

IV. LIABILITY

Each party hereto shall be responsible for any suits, demands, costs or actions at law resulting from its own acts or omissions and may insure against such possibilities as appropriate.

The Parties hereto understand and agree that the District, the County, their officers and employees are relying on, and do not waive or intend to waive by any provision of the Agreement, the monetary limitations or any other rights, immunities, and protections provided by the Colorado Governmental Immunity Act, C.R.S. 24-10-101 *et seq.*, as from time-to-time amended, or otherwise available to either party, their officers, or their employees.

V. NOTICES

A. Any notices, demands, or other communications required or permitted to be given by any provision of this Agreement shall be given in writing, delivered personally or sent by registered mail, postage prepaid and return receipt requested, addressed to Parties at the addresses set forth below or at such other address as either party may hereafter or from time to time designate by written notice to the other party given when personally delivered or mailed, and shall be considered received in the earlier of either the day on which such notice is actually received by the party to whom it is addressed or the third day after such notice is mailed.

For Adams County:

Adams County Manager's Office
4430 S. Adams County Parkway
Brighton, Colorado 80601-8206

Adams County Attorney's Office
4430 South Adams County Parkway, Suite C5000B
Brighton, Colorado 80601-8206

For District:

Southeast Weld County Fire Protection District
95 W. Broadway St.
Keenesburg, CO 80643
Attn: Irene Burke

B. The Parties each agree to designate and assign a representative to act on the behalf of said Parties in all matters related to this Agreement. Each representative shall coordinate all Agreement-related issues between the Parties, shall attend all necessary meetings, and shall be responsible for providing all available related information upon request by the County or the District. Said representatives shall have the authority for all approvals, authorizations, notices or concurrences required under this Agreement, but shall not be authorized to amend the terms of this Agreement.

VI. AMENDMENTS

This Agreement contains all of the terms agreed upon by and among the Parties. Any amendments or modifications to this Agreement shall be in writing and executed by the Parties hereto to be valid and binding.

VII. SEVERABILITY

If any clause or provision herein contained shall be adjudged to be invalid or unenforceable by a court of competent jurisdiction or by operation of any applicable law, such invalid or unenforceable clause or provision shall not affect the validity of the Agreement as a whole and all other clauses or provisions shall be given full force and effect.

VIII. APPLICABLE LAWS

This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado. Venue for any and all legal actions regarding the transaction covered herein shall lie in Adams County, Colorado.

IX. ASSIGNABILITY

No party to this Agreement shall assign or transfer any of its rights or obligations hereunder without the prior written consent of the non-assigning party or parties to this Agreement.

X. BINDING EFFECT

The provisions of this Agreement shall bind and shall inure to the benefit of the Parties hereto and to their respective successors and permitted assigns.

XI. EMPLOYMENT STATUS

This Agreement shall not change the employment status of any employees of the Parties. No party shall have the right to control or direct the activities of any employees of another related to this Agreement.

XII. NO DISCRIMINATION IN EMPLOYMENT

In connection with the performance of work under this Agreement, the Parties agree not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified because of race, color, ancestry, creed, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability and further agree to insert the foregoing provision in all subcontracts hereunder.

XIII. APPROPRIATIONS

Notwithstanding any other term, condition, or provision herein, each and every obligation of the Parties stated in this Agreement is subject to the requirement of a prior appropriation of funds therefor by the appropriate governing body of the District and/or the County.

XIV. NO THIRD PARTY BENEFICIARIES

It is expressly understood and agreed that enforcement of the terms and conditions of this Agreement, and all rights of action relating to such enforcement, shall be strictly reserved to the Parties, and nothing contained in this Agreement shall give or allow any such claim or right of action by any other or third person on such Agreement. It is the express intention of the Parties that any person or party other than either one of the Parties receiving services or benefits under this Agreement shall be deemed to be an incidental beneficiary only.

XV. ILLEGAL ALIENS

The Parties agree that any public contract for services executed as a result of this intergovernmental agreement shall prohibit the employment of illegal aliens in compliance with §8-17.5-101 C.R.S. et seq.

IN WITNESS WHEREOF, the Parties hereto have caused this instrument to be executed by properly authorized signatories as of the date and year first above written.

Signatures on next page.

SOUTHEAST WELD FIRE PROTECTION DISTRICT

By: Lisa O'Neil Board President

ATTEST:

Joan Stoner

APPROVED AS TO FORM:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____
Chair

ATTEST:

_____
Erica Hannah, Deputy Clerk

APPROVED AS TO FORM:

_____
Adams County Attorney's Office

CARES Distribution: Fire Districts

Fire District	Population Estimates	CARES Funding Per Population
Adams County Fire Protection District	92,366	$ 204,999.48
Bennett Fire Protection District	14,711	$ 32,649.97
Brighton Fire Rescue District	72,103	$ 160,027.25
Byers Fire Protection District	4,352	$ 9,658.94
Deer Trail Fire Protection District	4,352	$ 9,658.94
North Metro Fire District	153,475	$ 340,626.37
Sable-Altura Fire Protection District	22,189	$ 49,246.84
South Adams County Fire District	74,000	$ 164,237.51
Southeast Weld County Fire Protection District	8,667	$ 19,235.76
Strasburg Fire Protection District	4,352	$ 9,658.94
Total	450,567	$ 1,000,000.00
CARES Funding	$ 1,000,000.00	
Funding per Resident	$ 2.22	

ACS Estimates Population 2018 -extracted by fire district Census Tracts within or partially within Fire District

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Intergovernmental Agreement with Sable-Altura Fire Rescue District for distribution of CARES funds.
FROM: Alisha Reis, Deputy County Manager
AGENCY/DEPARTMENT: County Manager's Office/County Attorney's Office/Budget & Finance Department
HEARD AT STUDY SESSION ON: June 2, 2020
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the IGA to distribute CARES funds to Sable-Altura Fire Rescue District.

BACKGROUND:

Attached is an intergovernmental agreement for the Board's consideration to distribute a portion of funding allocated to the County by the Coronavirus Aid, Relief, and Economic Security Act (CARES). The County was allocated about $90.3 million, and the Board of County Commissioners previously agreed to allocate $1 million to fire districts serving Adams County. The Board also approved a funding formula based upon population of Adams County residents living within the fire districts. The formula is included as part of the IGA as Exhibit A.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

County Manager's Office
County Attorney's Office
Budget & Finance Department

ATTACHED DOCUMENTS:

Resolution
Intergovernmental Agreement

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION APPROVING INTERGOVERNMENTAL AGREEMENT BETWEEN THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF ADAMS AND SABLE-ALTURA FIRE RESCUE DISTRICT REGARDING DISBURSEMENT OF CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ACT FUNDS

WHEREAS, Section 18(2) of Article XIV of the Colorado Constitution and Sections 29-1-201, *et seq.* and 29-20-105 of the Colorado Revised Statutes authorize and encourage governments to cooperate by contracting with one another for their mutual benefit; and,

WHEREAS, the COVID-19 pandemic has created myriad economic distress and unanticipated costs in American society for individuals, families, businesses, and for the state and local governments addressing the pandemic's effects; and,

WHEREAS, Congress recently enacted the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 ("CARES") to provide relief funds to individuals, businesses, and state and local governments; and,

WHEREAS, CARES allows the County to directly receive funds for costs incurred in fighting and ameliorating the effects of COVID-19; and,

WHEREAS, pursuant to the terms of the Intergovernmental Agreement Between Adams County and Sable-Altura Fire Rescue District Regarding Disbursement of Coronavirus Aid, Relief and Economic Security Act Funds, the County wishes to disburse to District, and District wishes to receive from County, CARES funds for COVID-19 related costs incurred by District.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the Intergovernmental Agreement Between Adams County and Sable-Altura Fire Rescue District Regarding Disbursement of Coronavirus Aid, Relief and Economic Security Act Funds, is hereby approved.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners is authorized to execute said Intergovernmental Agreement.

INTERGOVERNMENTAL AGREEMENT BETWEEN ADAMS COUNTY AND SABLE ALTURA FIRE RESCUE DISTRICT REGARDING DISBURSEMENT OF CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ACT FUNDS

THIS INTERGOVERNMENTAL AGREEMENT ("Agreement"), is made this 19th day of August, 2020, by and between Adams County, Colorado, located at 4430 S. Adams County Parkway, Brighton, CO 80601 ("County") and Sable Altura Fire Rescue District located at 26900 E. Colfax Ave. #52, Aurora, CO ("District") for the purpose of disbursing funds provided by the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 ("CARES").

WITNESSETH:

WHEREAS, Section 18(2) of Article XIV of the Colorado Constitution and Sections 29-1-201, *et seq.* and 29-20-105 of the Colorado Revised Statutes authorize and encourage governments to cooperate by contracting with one another for their mutual benefit; and,

WHEREAS, the COVID-19 pandemic has created myriad economic distress and unanticipated costs in American society to individuals and families, to businesses, and to the state and local governments addressing the pandemic's effects; and,

WHEREAS, Congress recently enacted CARES to provide relief funds to individuals, businesses, and state and local governments; and,

WHEREAS, CARES allows the County to directly receive funds for costs incurred in fighting and ameliorating the effects of COVID-19; and,

WHEREAS, pursuant to the terms of this Agreement, the County wishes to disburse to District, and District wishes to receive from County, CARES funds for COVID-19 related costs incurred by District.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

I. FUNDING

CARES funds are allocated based on the percentage of the population in a given state that resides in the jurisdiction requesting direct funding from the federal government. County is similarly allocating CARES funds based on the percentage of the County population residing in each fire district. The spreadsheet attached as Exhibit A, and incorporated herein, shows the amount of CARES funds available to each Adams County fire district.

County will disburse to District the funds allocated to District in Exhibit A in a single payment. The payment will be disbursed to District only after County receives an invoice from District for the payment. District understands and agrees that the County's obligation to disburse these CARES funds is expressly contingent upon the County receiving said funds from the federal government. In the event the federal government fails to remit said funds, or reduces said funds, the County may reduce or terminate its payment accordingly. No Adams County funds shall be encumbered or involved in this Agreement.

District must submit reports on the expenditure of its CARES funds, including the amount and purpose of each expenditure, to County monthly. Any CARES funds not spent by December 4, 2020, shall be returned to the County so that the County's obligation to return unspent CARES funds to the Federal Treasury may be timely fulfilled.

II. SCOPE OF PROJECT AND ACCOUNTING

CARES funds shall be spent solely for the COVID-19 related costs set forth in CARES. CARES imposes expenditure and accounting obligations upon local governments receiving CARES funds. District agrees to be solely responsible for ensuring that it spends and accounts for the CARES funds received from the County in strict compliance with CARES requirements. Because CARES is recent legislation, the parties anticipate that additional federal legislation, rules, and regulations may be promulgated regarding the expenditure and accounting requirements. District shall familiarize itself with, and shall adhere to, all current and subsequent legislation, rules, and regulations. In the event of non-compliance with its legislative and regulatory mandates, the federal government may seek reimbursement of funds it deems were not spent in compliance with its legislation and rules. In the event the federal government seeks reimbursement of funds spent by District, District shall be solely responsible for reimbursing said funds, and, in the event the federal government seeks reimbursement of funds spent by

District from County, District shall reimburse County for any funds returned by County on District's behalf within thirty days of County's reimbursement.

III. PUBLIC NECESSITY

The Parties agree that the work performed pursuant to this Agreement is necessary for the health, safety, comfort, convenience, and welfare of all the people in Adams County in the fight against COVID-19.

IV. LIABILITY

Each party hereto shall be responsible for any suits, demands, costs or actions at law resulting from its own acts or omissions and may insure against such possibilities as appropriate.

The Parties hereto understand and agree that the District, the County, their officers and employees are relying on, and do not waive or intend to waive by any provision of the Agreement, the monetary limitations or any other rights, immunities, and protections provided by the Colorado Governmental Immunity Act, C.R.S. 24-10-101 *et seq.*, as from time-to-time amended, or otherwise available to either party, their officers, or their employees.

V. NOTICES

A. Any notices, demands, or other communications required or permitted to be given by any provision of this Agreement shall be given in writing, delivered personally or sent by registered mail, postage prepaid and return receipt requested, addressed to Parties at the addresses set forth below or at such other address as either party may hereafter or from time to time designate by written notice to the other party given when personally delivered or mailed, and shall be considered received in the earlier of either the day on which such notice is actually received by the party to whom it is addressed or the third day after such notice is mailed.

For Adams County:

Adams County Manager's Office
4430 S. Adams County Parkway
Brighton, Colorado 80601-8206

Adams County Attorney's Office
4430 South Adams County Parkway, Suite C5000B
Brighton, Colorado 80601-8206

For District:

Sable Altura Fire Rescue District
26900 E. Colfax Ave. #52
Aurora, CO 80018

Attn: Hope Williams

B. The Parties each agree to designate and assign a representative to act on the behalf of said Parties in all matters related to this Agreement. Each representative shall coordinate all Agreement-related issues between the Parties, shall attend all necessary meetings, and shall be responsible for providing all available related information upon request by the County or the District. Said representatives shall have the authority for all approvals, authorizations, notices or concurrences required under this Agreement, but shall not be authorized to amend the terms of this Agreement.

VI. AMENDMENTS

This Agreement contains all of the terms agreed upon by and among the Parties. Any amendments or modifications to this Agreement shall be in writing and executed by the Parties hereto to be valid and binding.

VII. SEVERABILITY

If any clause or provision herein contained shall be adjudged to be invalid or unenforceable by a court of competent jurisdiction or by operation of any applicable law, such invalid or unenforceable clause or provision shall not affect the validity of the Agreement as a whole and all other clauses or provisions shall be given full force and effect.

VIII. APPLICABLE LAWS

This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado. Venue for any and all legal actions regarding the transaction covered herein shall lie in Adams County, Colorado.

IX. ASSIGNABILITY

No party to this Agreement shall assign or transfer any of its rights or obligations hereunder without the prior written consent of the non-assigning party or parties to this Agreement.

X. BINDING EFFECT

The provisions of this Agreement shall bind and shall inure to the benefit of the Parties hereto and to their respective successors and permitted assigns.

XI. EMPLOYMENT STATUS

This Agreement shall not change the employment status of any employees of the Parties. No party shall have the right to control or direct the activities of any employees of another related to this Agreement.

XII. NO DISCRIMINATION IN EMPLOYMENT

In connection with the performance of work under this Agreement, the Parties agree not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified because of race, color, ancestry, creed, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability and further agree to insert the foregoing provision in all subcontracts hereunder.

XIII. APPROPRIATIONS

Notwithstanding any other term, condition, or provision herein, each and every obligation of the Parties stated in this Agreement is subject to the requirement of a prior appropriation of funds therefor by the appropriate governing body of the District and/or the County.

XIV. NO THIRD PARTY BENEFICIARIES

It is expressly understood and agreed that enforcement of the terms and conditions of this Agreement, and all rights of action relating to such enforcement, shall be strictly reserved to the Parties, and nothing contained in this Agreement shall give or allow any such claim or right of action by any other or third person on such Agreement. It is the express intention of the Parties that any person or party other than either one of the Parties receiving services or benefits under this Agreement shall be deemed to be an incidental beneficiary only.

XV. ILLEGAL ALIENS

The Parties agree that any public contract for services executed as a result of this intergovernmental agreement shall prohibit the employment of illegal aliens in compliance with §8-17.5-101 C.R.S. et seq.

IN WITNESS WHEREOF, the Parties hereto have caused this instrument to be executed by properly authorized signatories as of the date and year first above written.

Signatures on next page.

SABLE ALTURAS FIRE RESCUE

By: Chair

ATTEST:

Hope Williams, Secretary

APPROVED AS TO FORM:

Rich Solomon, Fire Chief

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

Chair

ATTEST:

Erica Hannah, Deputy Clerk

APPROVED AS TO FORM:

Adams County Attorney's Office

CARES Distribution: Fire Districts

Fire District	Population Estimates	CARES Funding Per Population
Adams County Fire Protection District	92,366	$ 204,999.48
Bennett Fire Protection District	14,711	$ 32,649.97
Brighton Fire Rescue District	72,103	$ 160,027.25
Byers Fire Protection District	4,352	$ 9,658.94
Deer Trail Fire Protection District	4,352	$ 9,658.94
North Metro Fire District	153,475	$ 340,626.37
Sable-Altura Fire Protection District	22,189	$ 49,246.84
South Adams County Fire District	74,000	$ 164,237.51
Southeast Weld County Fire Protection District	8,667	$ 19,235.76
Strasburg Fire Protection District	4,352	$ 9,658.94
Total	450,567	$ 1,000,000.00
CARES Funding	$ 1,000,000.00	
Funding per Resident	$ 2.22	

ACS Estimates Population 2018 -extracted by fire district Census Tracts within or partially within Fire District

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Agreement with Colorado Legal Services for distribution of CARES funds.
FROM: Alisha Reis, Deputy County Manager
AGENCY/DEPARTMENT: County Manager's Office/County Attorney's Office/Budget & Finance Department
HEARD AT STUDY SESSION ON: June 23, 2020
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the agreement to distribute CARES funds to Colorado Legal Services.

BACKGROUND:

Attached is an agreement for the Board's consideration to distribute a portion of funding allocated to the County by the Coronavirus Aid, Relief, and Economic Security Act (CARES). The County was allocated about $90.3 million, and the Board of County Commissioners previously agreed to allocate $250,000 to Colorado Legal Services for legal services related to evictions brought on by income loss or other circumstances related to the COVID-19 pandemic.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

County Manager's Office
County Attorney's Office
Budget & Finance Department

ATTACHED DOCUMENTS:

Resolution
Funding Agreement

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION APPROVING AGREEMENT BETWEEN THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF ADAMS AND COLORADO LEGAL SERVICES REGARDING DISBURSEMENT OF CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ACT FUNDS

WHEREAS, the COVID-19 pandemic has created myriad economic distress and unanticipated costs in American society for individuals, families, businesses, and for the state and local governments addressing the pandemic's effects; and,

WHEREAS, Congress recently enacted the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 ("CARES") to provide relief funds to individuals, businesses, and state and local governments; and,

WHEREAS, CARES allows the County to directly receive funds for costs incurred in fighting and ameliorating the effects of COVID-19; and,

WHEREAS, pursuant to the terms of the Agreement Between Adams County and Colorado Legal Services Regarding Disbursement of Coronavirus Relief and Economic Security Act Funds, the County wishes to disburse to Colorado Legal Services, and Colorado Legal Services wishes to receive from the County, CARES funds for disbursement to organizations and entities serving Adams County residents for COVID-19 related costs.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the Agreement between the Board of County Commissioners of the County of Adams and Colorado Legal Services regarding disbursement of Coronavirus Aid, Relief and Economic Security Act Funds, is hereby approved.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners is authorized to execute said Agreement.

AGREEMENT BETWEEN ADAMS COUNTY AND COLORADO LEGAL SERVICES REGARDING DISBURSEMENT OF CORONAVIRUS AID, RELIEF AND ECONOMIC SECURITY ACT FUNDS

THIS AGREEMENT ("Agreement"), is made this _____ day of August, 2020, by and between Adams County, Colorado, located at 4430 S. Adams County Parkway, Brighton, CO 80601 ("County") and COLORADO LEGAL SERVICES, located at 1905 Sherman Street, Suite 400, Denver, CO 80203, for the purpose of disbursing funds provided by the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 ("CARES").

WITNESSETH:

WHEREAS, the COVID-19 pandemic has created myriad economic distress and unanticipated costs in American society to individuals and families, to businesses, and to the state and local governments addressing the pandemic's effects; and,

WHEREAS, Congress recently enacted CARES to provide relief funds to individuals, businesses, and state and local governments; and,

WHEREAS, CARES allows the County to directly receive funds for costs incurred in fighting and ameliorating the effects of COVID-19; and,

WHEREAS, pursuant to the terms of this Agreement, the County wishes to disburse to COLORADO LEGAL SERVICES, and COLORADO LEGAL SERVICES wishes to receive from the County, CARES funds for disbursement to organizations and entities serving Adams County residents for COVID-19 related costs.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

I. FUNDING

County will disburse a maximum of TWO HUNDRED FIFTY THOUSAND dollars ($250,000) to COLORADO LEGAL SERVICES. Payments will be disbursed to COLORADO LEGAL SERVICES monthly, only after County receives an invoice from COLORADO LEGAL SERVICES for each month's payment. COLORADO LEGAL SERVICES understands and agrees that the County's obligation to disburse these CARES funds is expressly contingent upon the County receiving said funds from the federal government. In the event the federal government fails to remit said funds, or reduces said funds, the County may reduce or terminate its payment accordingly. No Adams County funds shall be encumbered or involved in this Agreement.

COLORADO LEGAL SERVICES must submit reports no later than the 5th day of each month on the expenditure of its CARES funds, including the amount and purpose of each expenditure, to County monthly. Any CARES funds not spent by December 4, 2020, shall be returned to the County so that the County's obligation to return unspent CARES funds to the Federal Treasury may be timely fulfilled.

II. SCOPE OF PROJECT AND ACCOUNTING

CARES funds shall be spent solely for the COVID-19 related costs set forth in CARES. CARES imposes expenditure and accounting obligations upon local governments receiving CARES funds. COLORADO LEGAL SERVICES agrees to be solely responsible for ensuring that it disburses and accounts for the CARES funds received from the County in strict compliance with CARES requirements. Because CARES is recent legislation, the parties anticipate that additional federal legislation, rules, and regulations may be promulgated regarding the expenditure and accounting requirements. COLORADO LEGAL SERVICES shall familiarize itself with, and shall adhere to, all current and subsequent legislation, rules, and regulations. In the event of non-compliance with its legislative and regulatory mandates, the federal government may seek reimbursement of funds it deems were not spent in compliance with its legislation and rules. In the event the federal government seeks reimbursement of funds disbursed by COLORADO LEGAL SERVICES, then COLORADO LEGAL SERVICES shall be solely responsible for reimbursing said funds, and, in the event the federal government seeks reimbursement of funds disbursed by COLORADO LEGAL SERVICES from County, COLORADO LEGAL SERVICES shall reimburse County for any funds returned by County on COLORADO LEGAL SERVICES' behalf within thirty days of County's reimbursement.

III. PUBLIC NECESSITY

The Parties agree that the work performed pursuant to this Agreement is necessary for the health, safety, comfort, convenience, and welfare of all the people in Adams County in the fight against COVID-19.

IV. LIABILITY

Each party hereto shall be responsible for any suits, demands, costs or actions at law resulting from its own acts or omissions and may insure against such possibilities as appropriate.

The Parties hereto understand and agree that the County, its officers and employees are relying on, and do not waive or intend to waive by any provision of the Agreement, the monetary limitations or any other rights, immunities, and protections provided by the Colorado Governmental Immunity Act, C.R.S. 24-10-101 *et seq.*, as from time-to-time amended, or otherwise available to either party, their officers, or their employees.

V. NOTICES

A. Any notices, demands, or other communications required or permitted to be given by any provision of this Agreement shall be given in writing, delivered personally or sent by registered mail, postage prepaid and return receipt requested, addressed to Parties at the addresses set forth below or at such other address as either party may hereafter or from time to time designate by written notice to the other party given when personally delivered or mailed, and shall be considered received in the earlier of either the day on which such notice is actually received by the party to whom it is addressed or the third day after such notice is mailed.

For Adams County:

Adams County Manager's Office
4430 S. Adams County Parkway
Brighton, Colorado 80601-8206
Attn: Alisha Reis, areis@adcogov.org

Adams County Attorney's Office
4430 South Adams County Parkway, Suite C5000B
Brighton, Colorado 80601-8206

For COLORADO LEGAL SERVICES:

COLORADO LEGAL SERVICES
1905 Sherman Street, Suite 400
Denver, CO 80203

Attn: Jonathan D. Asher
Executive Director
jasher@colegalserv.org

B. The Parties each agree to designate and assign a representative to act on the behalf of said Parties in all matters related to this Agreement. Each representative shall coordinate all Agreement-related issues between the Parties, shall attend all necessary meetings, and shall be responsible for providing all available related information upon request by the County or COLORADO LEGAL SERVICES. Said representatives shall have the authority for all approvals, authorizations, notices or concurrences required under this Agreement, but shall not be authorized to amend the terms of this Agreement.

VI. AMENDMENTS

This Agreement contains all of the terms agreed upon by and among the Parties. Any amendments or modifications to this Agreement shall be in writing and executed by the Parties hereto to be valid and binding.

VII. SEVERABILITY

If any clause or provision herein contained shall be adjudged to be invalid or unenforceable by a court of competent jurisdiction or by operation of any applicable law, such invalid or unenforceable clause or provision shall not affect the validity of the Agreement as a whole and all other clauses or provisions shall be given full force and effect.

VIII. APPLICABLE LAWS

This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado. Venue for any and all legal actions regarding the transaction covered herein shall lie in Adams County, Colorado.

IX. ASSIGNABILITY

No party to this Agreement shall assign or transfer any of its rights or obligations hereunder without the prior written consent of the non-assigning party or parties to this Agreement.

X. BINDING EFFECT

The provisions of this Agreement shall bind and shall inure to the benefit of the Parties hereto and to their respective successors and permitted assigns.

XI. EMPLOYMENT STATUS

This Agreement shall not change the employment status of any employees of the Parties. No party shall have the right to control or direct the activities of any employees of another related to this Agreement.

XII. NO DISCRIMINATION IN EMPLOYMENT

In connection with the performance of work under this Agreement, the Parties agree not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified because of race, color, ancestry, creed, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability and further agree to insert the foregoing provision in all subcontracts hereunder.

XIII. APPROPRIATIONS

Notwithstanding any other term, condition, or provision herein, each and every obligation of the Parties stated in this Agreement is subject to the requirement of a prior appropriation of funds therefor by the appropriate governing body of the County.

XIV. NO THIRD PARTY BENEFICIARIES

It is expressly understood and agreed that enforcement of the terms and conditions of this Agreement, and all rights of action relating to such enforcement, shall be strictly reserved to the Parties, and nothing contained in this Agreement shall give or allow any such claim or right of action by any other or third person on such Agreement. It is the express intention of the Parties that any person or party other than either one of the Parties receiving services or benefits under this Agreement shall be deemed to be an incidental beneficiary only.

XV. ILLEGAL ALIENS

The Parties agree that any public contract for services executed as a result of this agreement shall prohibit the employment of illegal aliens in compliance with §8-17.5-101 C.R.S. et seq.

IN WITNESS WHEREOF, the Parties hereto have caused this instrument to be executed by properly authorized signatories as of the date and year first above written.

Signatures on next page.

COLORADO LEGAL SERVICES

By: Jonathan D. Asher

ATTEST:

APPROVED AS TO FORM:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

Chair

ATTEST:

Erica Hannah, Deputy Clerk

APPROVED AS TO FORM:

Adams County Attorney's Office

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: September 1, 2020
SUBJECT: Detention Facility Module "B" Sanitary Sewer Replacement
FROM: Raymond H. Gonzales, County Manager Alisha Reis, Deputy County Manager Nancy Duncan, Budget & Finance Director Jennifer Tierney Hammer, Procurement & Contracts Manager
AGENCY/DEPARTMENT: Facilities and Fleet Management Department and Sheriff's Office
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves an agreement with JCOR Mechanical, Inc., for the Detention Facility Module "B" Sanitary Sewer Replacement.

BACKGROUND:

The current sanitary sewer line that services the "B" Module at the Detention Facility is failing and needs to be replaced. The sanitary sewer line for the Detention Facility is approximately 35 years old and has served its useful life in a building with year-round operations. The current cast iron pipe is starting to shale, has cracks and is developing areas of weakness. The old pipes will be replaced with PVC pipe which have a longer life expectancy.

A formal Invitation for Bid (IFB) was solicited through BidNet for the Detention Facility Module "B" Sanitary Sewer Replacement. The County received three responses on June 2, 2020.

- JCOR Mechanical, Inc. - $474,898.00
- Amy C Enterprise dba Foster Plumbing - $516,439.47
- Colorado Mechanical Systems, Inc. – non-responsive

The Facilities and Fleet Management Department recommends that an agreement with JCOR Mechanical, Inc., for the Detention Facility Module "B" Sanitary Sewer Replacement in the not to exceed amount of $474,898.00 be approved.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Facilities and Fleet Management Department
Sheriff's Office

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 01

Cost Center: 2009

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:	9105	20092006	$600,000
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$600,000

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AN AGREEMENT BETWEEN ADAMS COUNTY AND JCOR MECHANICAL, INC., FOR THE DETENTION FACILITY MODULE "B" SANITARY SEWER REPLACEMENT

WHEREAS, JCOR Mechanical, Inc., submitted a bid on June 2, 2020, to provide the Detention Facility Module "B" Sanitary Sewer Replacement; and,

WHEREAS, JCOR Mechanical, Inc., agrees to provide the Detention Facility Module "B" Sanitary Sewer Replacement in the not to exceed amount of $474,898.00.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Agreement Between Adams County and JCOR Mechanical, Inc., for the Detention Facility Module "B" Sanitary Sewer Replacement is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign said Agreement on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

CASE NO: RCU2020-00004
CASE NAME: Pioneer Produced Water Pipeline Project

TABLE OF CONTENTS

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

Planning Commission — August 13, 2020

Case Number.:	**RCU2020-00004**
Case Name:	**Pioneer Produced Water Pipeline Project**
Applicant's Name:	Spence McCallie, Pioneer Water Pipeline, LLC
Applicant's Address:	600 17th Street, Suite 725, Denver, CO 80202
Location of Request:	Multiple Parcels in Adams County. The linear pipeline project stretches from the vicinity of the intersection of East 136th Avenue and Buckley Road to the vicinity of the intersection of East 168th Avenue and Quebec Street
Nature of Request:	1) Conditional Use Permit (CUP) to construct a new pipeline system conveying produced water 2) Development Agreement that covers pre-construction requirements, construction and operational standards, and maintenance of the pipelines.
Zone Districts:	Agricultural-1 (A-1), Agricuture-3 (A-3), Planned Unit Development (PUD), Public Lands (PL), Residential Estate (RE)
Site Size:	Total length of the pipelines is approximately 12.3 miles in unincorporated Adams County
Proposed Uses:	Oil & Gas Infrastructure
Existing Use:	Agriculture, single-family homes, open space, & vacant land
Hearing Date(s):	**PC: August 13, 2020 / 6:00 p.m.** **BOCC: September 1, 2020 / 9:30 a.m.**
Report Date:	August 7, 2020
Case Manager:	Greg Barnes
Staff Recommendation:	APPROVAL with 33 findings-of-fact, 1 condition, and 1 note.

SUMMARY OF APPLICATION

Background

The applicant, Pioneer Water Pipeline, LLC (a subsidiary of Expedition Water Solutions Colorado, LLC) is requesting a conditional use permit to allow construction of a new pipeline system. The pipeline will measure 4-12 inches in diameter, and the applicant has designed the Project to allow for expansion and additional capacity in the future if there is a need and

economic feasibility to serve additional oil and gas facilities. According to the applicant, the request to allow construction of the pipeline is to transport produced water from oil and gas production facilities. The pipeline would reduce local truck traffic associated with transporting such materials by vehicles to the Expedition Water Solutions #6 Wastewater Injection and Disposal facility in Weld County. Wastewater injection is a process of disposing of fluid underground into geologic formations that can hold fluid. According to the applicant, it is estimated that oil and gas production facilities generate approximately half as much water as product, meaning that for every two barrels of product generated at an oil and gas production facility, an operator must dispose of one barrel of produced water. Without this Project, the operators of the oil and gas production facilities in Adams and Weld Counties that would be connected by the proposed pipeline would transport the water generated during production by truck. The applicant has cited that the construction of this project would create numerous benefits for the region, including: the reduction of an estimated 5,000,000 truck miles and over 50,000 truckloads per year on local roads; fewer repairs to streets and highways of the community; a reduction in the potential for traffic accidents; better air quality by reduced vehicle emissions and particulates, ozone, odors, and other air pollutants in the atmosphere; reduction of carbon emissions by 21,000 metric tons per year; and creation of 100 locally sourced jobs during construction, and approximately four permanent jobs once operational.

The Project would consist of construction of approximately 48.5 miles of high-density polyethylene (HDPE) produced water gathering pipelines and associated appurtenances in Adams and Weld Counties. Approximately 29 miles of pipeline is proposed in Weld County, and 19 miles of pipeline is proposed in Adams County. Of the 19 miles of pipeline proposed for Adams County, approximately 12 miles is proposed for unincorporated Adams County, affecting 42 parcels. The remaining 7 miles are proposed within the city limits of Brighton and Thornton.

The site plan provided with the application (Exhibit 3.1) shows the pipeline network will be interconnected between as many as fifteen existing well pad sites within Adams County. The easternmost point in Adams County of the pipeline network will be within the City of Brighton, near the intersection of Buckley Road and East 136th Avenue. The pipeline will continue westward on East 136th Avenue to Brighton Road. After crossing Brighton Road, the preferred pipeline route continues in a northwesterly direction along E-470 continuing just west of York Street. Along this portion of the pipeline, a spur continues northward beginning just to the east of Colorado Boulevard and stretches to connect several well pads in that area. Two additional segments of the pipeline network also impact unincorporated portions of Adams County. A section of the pipeline is proposed along the southern side of State Highway 7 between Colorado Boulevard and Quebec Street. At Quebec Street, the pipeline then crosses Highway 7 and continues north. An additional section of the network will begin along Riverdale Road and traverse northbound along the western side of Tucson Street before crossing into Weld County.

Development Standards and Regulations Requirements

The County's Development Standards and Regulations outlines requirements for a conditional use permit. Specifically, Section 2-02-08 of the County's Development Standards requires an applicant to demonstrate that the request for a conditional use permit is compatible with the surrounding area, not detrimental to the immediate area, all off-site impacts have been addressed, and that the site plan will provide the most convenient and functional use of the lots.

The subject request includes submittal information outlined in Section 6-07-02 of the County's Development Standards and Regulations pertaining to Areas and Activities of State Interest permits. This information is relevant for large-scale projects and addresses issues on environmental concerns, finance, and other relevant issues to address. Submittal items required and outlined in the Development Standards includes the following information:

- Detailed applicant information
- Extensive information regarding the project
- Information on property rights, permits, and other approvals
- Financial feasibility of the project
- Land use
- Local governmental services
- Financial burden on residents
- Local economy
- Environmental impact analysis: this includes analysis on water (surface and ground water), visual impacts, air quality, wetland and riparian areas, flora and fauna, soils, geologic conditions, and areas of paleontological, historic or archaeological importance.

Staff reviewed documentation submitted with the applications and has determined that the information provided adequately conforms to the requirements for Areas and Activities of State Interest. The application documents included information about the company and their financial ability to fund the project. Routing analysis submitted with the application also justified selection of the preferred routes. The preferred alignments are those that best minimize potential impacts on existing residential developments. In addition, most of the properties that the pipelines traverse through are predominately used for agriculture. The construction of the pipelines would not impede current or future uses of the surrounding properties. Staff reviewed environmental impact report included with the application and determined procedures and guidelines outlined in the report adequately demonstrate protection and preservation of water resources, visual impacts, air quality, wetland and riparian areas, flora and fauna, soils, geologic conditions, and areas of paleontological, historic or archaeological importance.

Per Section 6-07-02-03 of the County's Development Standards and Regulations, the applicant is required to submit a routing analysis with at least three alternative routes for each of the proposed pipelines. The applicant provided this information. According to the applicant, a preferred route was determined to have the least impacts on existing residential uses, as well as minimal impact on agriculturally utilized lands within unincorporated Adams County.

Development Agreement

As part of the conditional use permit application, the applicant has agreed to enter into a development agreement with the County for each of the proposed pipelines. The agreement covers multiple requirements, such as pre-construction approvals (which include stormwater, road crossing, and traffic control permits), documentation of standard operating procedures, and maintenance of the pipeline. In addition, the development agreement is required to address all

comments from various review agencies. The development agreement conforms to the requirements.

The applicant will also be responsible to maintain all likely affected Adams County roadway infrastructure by cleaning the roads and repairing any damage. The agreement requires the pipeline route to be located out of future road right-of-ways. Any land disturbed by construction in the project area is also required to be restored. Finally, the agreement requires the developer to avoid areas where regional drainage improvements may occur. If avoiding such infrastructure is impossible, then the developer, at its own expense, will be required to relocate the pipeline whenever such drainage improvement occurs. The development agreement is attached to this report for review and consideration (see exhibit 6.7).

Future Land Use Designation/Goals of the Comprehensive Plan for the Area:

The preferred pipeline route affects seven future land use designations. Specifically, those designations are: Mixed-Use Neighborhood, Agriculture, Parks and Open Space, Mixed-Use Employment, Local District Mixed-Use, Commercial, and Estate Residential. Analysis of each of these future land use designations and their intended purposes are discussed below:

Goals of the Mixed-Use Neighborhood Future Land Use:

The Mixed Use Neighborhood future land use allows for a range of urban level residential uses, including single and multi-family housing combined with compatible and supporting uses and activities that serve the neighborhood and are developed and operated in harmony with the residential characteristics of a neighborhood. Seven of the nine parcels that the pipeline traverses are designated as Mixed-Use Neighborhood. Current land use activities on these parcels are agricultural with some existing and proposed oil and gas wells. The pipeline path would be located on the edges of the impacted parcels and outside any future road rights-of-way. Location of the pipeline would not hinder development of the properties or surrounding areas from achieving the goals of the Mixed-Use Neighborhood future land use designation.

Goals of the Mixed-Use Employment Future Land Use:

This land use category allows a mixture of employment uses, including offices, retail, and clean, indoor manufacturing, distribution, warehousing, and airport and technology uses. New Mixed-Use Employment areas are designated in locations that will have excellent transportation access and visibility but are not suitable for residential uses. Large swaths of properties around Denver International Airport, Front Range Airport, and the I-70 corridor are designated for future Mixed Use Employment to preserve future long-term opportunities for employment growth in these areas, but any future development in these areas should be phased and concentrated around where urban services and infrastructure are most readily available.

Goals of the Commercial Future Land Use:

Commercial areas are intended to serve either neighborhood or regional needs and can be comprised of a variety of uses, including retail sales, restaurants and other services, and professional and commercial offices. The primary objective of the Commercial land use designation is to support and attract businesses that provide employment opportunities, meet the needs of County residents and visitors, and contribute to the County's tax base. Commercial

areas should be compatible with surrounding development, and located in areas with adequate transportation access, services, and public infrastructure. Building materials, architectural design, relationship to streets, sidewalks, and parking areas, should all contribute positively to the aesthetic character of the area.

Goals of the Agriculture Future Land Use:
The areas that have been identified as agricultural are those that are not expected to develop, except for limited areas of very low density residential at densities of 1 dwelling per 35 acres, for the foreseeable future. These areas are typically characterized by a lack of urban services.

Goals of the Estate Residential Future Land Use:
The Estate Residential future land designated areas are for single family housing at lower densities, typically no greater than 1 unit per acre, and compatible uses such as schools and parks. The main goal for the Estate Residential future land use areas is to provide limited opportunities for ex-urban or rural lifestyles in the County.

Goals of the Local District Mixed-Use Future Land Use:
The Local District Mixed-Use Designation is assigned for areas within the Historic Splendid Valley Plan. This area is an eclectic agricultural area established through a partnership with the City of Brighton and Adams County. The area is focused on preserving farmland and stimulating innovative opportunities that create closer connections between people, farming, and nature.

Goals of the Parks & Open Space Future Land Use:
The primary uses in this category are public parks, trails and open space. In most cases, land uses in this category will be open to the public. Development is limited to recreational facilities and maintenance and other facilities that serve the site. The primary objectives of these areas are to provide land for recreation and enjoyment, provide areas for wildlife, and preserve especially sensitive, beautiful, or historic areas.

The preferred pipeline has been designed (as indicated on the site plan, Exhibit 3.1) to not hinder development of the surrounding properties from achieving the goals of the associated future land use designation. Although some hindrance may be possible for future vertical development where the 10-foot wide easement is located, it is not expected to negatively impact the County's long-term goals in the area. The affected parcels can be developed in a manner consistent with the future land use designation goals.

Site Characteristics:
The preferred pipeline route will traverse through 42 properties in unincorporated Adams County. On its easternmost end, the route runs along the northern edge of East 136th Avenue between Brighton Road and Sable Boulevard. This region consists largely of vacant, agricultural, and rural residential uses. The region is part of the Historic Splendid Valley District. The route continues to west and enters unincorporated Adams County again along the edges of E-470 between the South Platte River and Colorado Boulevard. These areas are mostly vacant lands and rural residential uses. The route runs along the northern edge of the Ridge at Riverdale subdivision. Several pockets of the pipeline system are located north of East 152nd Avenue stretching to the Weld County line at East 168th Avenue. These three sections of the pipeline

generally run in a north-south direction in the vicinities of Colorado Boulevard, Quebec Street, and Tucson Street. These three portions of the pipeline route are all characteristic of rural residential uses, agricultural, and vacant lands. The proposed produced water pipeline may have some initial impacts during construction but will ultimately reduce traffic and improve air quality in the region by eliminating the need for trucking of the produced water to the injection sites. Measures are included in the associated Development Agreement to reduce the impacts of the pipeline's construction process on nearby property owners.

Compatibility with the Surrounding Land Uses:

Most of the area surrounding the pipeline is comprised of agriculturally zoned and used properties, as well as single-family homes. According to the applicant, the pipeline would be buried and strategically placed along perimeters of properties and outside future road right-of-ways. This is to minimize potential impacts to surrounding properties. The proposed request would not negatively impact existing surrounding uses.

There are oil and gas developments existing or proposed in the immediate vicinity of the subject pipeline. This pipeline would service those oil and gas wells, which will substantially reduce truck traffic associated with transporting of products from the gas wells. In addition, the pipeline will support gathering, processing, and transporting oil and gas products from Adams County without causing impacts to the local transportation system.

Staff Recommendation:

Based upon the application, the criteria for conditional use permit approval, and a recent site visit, staff recommends approval of the conditional use permit with 33 findings-of-fact, 1 condition, and 1 note.

Staff also recommends approval of the development agreement.

Recommended Findings-of-Fact:

1. The conditional use is permitted in the applicable zone district.
2. The conditional use is consistent with the purposes of these standards and regulations.
3. The conditional use will comply with the requirements of these standards and regulations including, but not limited to, all applicable performance standards.
4. The conditional use is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
5. The conditional use permit has addressed all off-site impacts.
6. The site is suitable for the conditional use including adequate usable space, adequate access, and absence of environmental constraints.
7. The site plans for the proposed conditional use will provide the most convenient and functional use of the lot including the parking scheme, traffic circulation, open space, fencing, screening, landscaping, signage, and lighting.
8. Sewer, water, storm water drainage, fire protection, police protection, and roads are to be available and adequate to serve the needs of the conditional use as designed and proposed.

9. Documentation that prior to site disturbance associated with the Proposed Project, the Applicant can and will obtain all necessary property rights, permits and approvals. The Board may, at its discretion, defer making a final decision on the application until outstanding property rights, permits and approvals are obtained or the Board may grant a Permit with conditions and/or conditions precedent which will adequately address outstanding concerns.
10. The Proposed Project considers the relevant provisions of the regional water quality plans.
11. The Applicant has the necessary expertise and financial capability to develop and operate the Proposed Project consistent with all requirements and conditions.
12. The Proposed Project is technically and financially feasible.
13. The Proposed Project is not subject to significant risk from Natural Hazards.
14. The Proposed Project is in general conformity with the applicable comprehensive plans.
15. The Proposed Project does not have a significant adverse effect on the capability of local government to provide services or exceed the capacity of service delivery systems.
16. The Proposed Project does not create an undue financial burden on existing or future residents of the County.
17. The Proposed Project does not significantly degrade any substantial sector of the local economy.
18. The Proposed Project does not unduly degrade the quality or quantity of recreational opportunities and experience.
19. The planning, design and operation of the Proposed Project reflects principals of resource conservation, energy efficiency and recycling or reuse.
20. The Proposed Project does not significantly degrade the environment. This includes the considerations that shall be used to determine whether there will be significant degradation of the environment. For purposes of this section, the term environment shall include:
    - Air quality,
    - Visual quality,
    - Surface water quality,
    - Groundwater quality,
    - Wetlands, flood plains, streambed meander limits, recharge areas, and riparian areas,
    - Terrestrial and aquatic animal life,
    - Terrestrial and aquatic plant life, and
    - Soils and geologic conditions.
21. The Proposed Project does not cause a nuisance and, if a nuisance has been determined to be created by the Proposed Project, the nuisance has been mitigated to the satisfaction of the County.
22. The Proposed Project does not significantly degrade areas of paleontological, historical, or archaeological importance.
23. The Proposed Project does not result in unreasonable risk of releases of hazardous materials. In making this determination as to such risk, the Board's consideration shall include:
    - Plans for compliance with Federal and State handling, storage, disposal and transportation requirements,
    - Use of waste minimization techniques, and
    - Adequacy of spill prevention and counter measures, and emergency response plans.
24. The benefits accruing to the County and its citizens from the proposed activity outweigh the losses of any resources within the County, or the losses of opportunities to develop such resources.

25. The Proposed Project is the best alternative available based on consideration of need, existing technology, cost, impact and these Regulations.
26. The Proposed Project shall not unduly degrade the quality or quantity of agricultural activities.
27. The proposed Project does not negatively affect transportation in the area.
28. All reasonable alternatives to the Proposed Project, including use of existing rights-of-way and joint use of rights-of-way wherever uses are compatible, have been adequately assessed and the Proposed Project is compatible with and represents the best interests of the people of the County and represents a fair and reasonable utilization of resources in the Impact Area.
29. The nature and location of the Proposed Project or expansion will not unduly interfere with existing easements, rights-of-way, other utilities, canals, mineral claims or roads.
30. Adequate electric, gas, telephone, water, sewage and other utilities exist or shall be developed to service the site.
31. The proposed project will not have a significantly adverse Net Effect on the capacities or functioning of streams, lakes and reservoirs in the impact area, nor on the permeability, volume, recharge capability and depth of aquifers in the impact area.
32. The purpose and need for the Proposed Project are to meet the needs of an increasing population within the County, the area and community development plans and population trends clearly demonstrate a need for such development.
33. The Proposed Project is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area.

Recommended Condition of Approval:

1. The applicant shall comply with all the terms and conditions of the executed Development Agreement between Pioneer Water Pipeline, LLC and Adams County.

Recommended Note to Applicant:

1. The applicant shall execute the Development Agreement associated with the conditional use permit prior to the scheduled September 1, 2020 Board of County Commissioners hearing. The executed Development Agreement shall be submitted to Adams County staff no later than August 28, 2020.

PUBLIC COMMENTS

Notifications Sent	Number of Responses
728	1

Staff sent referrals to all property owners within 1,000 feet of the pipeline route. As of writing this report, staff has received one comment from a property owner who is supportive of the request as long as the project is deemed safe for the public (see exhibit 5.1).

COUNTY AGENCY COMMENTS

The Adams County Development Services Division requested that the pipeline shall be located within permanent easements. The applicant will ensure that the pipeline will only cross County-maintained street right-of-way at or near a perpendicular angle and that any segment of the pipeline constructed parallel to an Adams County right-of-way will be constructed a minimum of five (5) feet from the edge of the maximum future right-of-way width.

REFERRAL AGENCY COMMENTS

Responding with Comments or Concerns:

City of Thornton (Exhibit 4.2)

- Thornton requested the applicant to incorporate the design and alignment of the City of Thornton's 42-inch raw water pipeline into the design and alignment of the Pioneer Water Pipeline along Quebec Street between 160th and 168th. No conflicts are expected. The applicant will apply for a Floodplain Development Permit from the City of Thornton if work within a FEMA floodplain or other Special Hazard Area is Required. Additionally, the applicant will ensure that the applicable permits for right-of-way crossings within the City of Thornton's jurisdiction have been approved by the City of Thornton's Infrastructure Department prior to construction. Prior to construction within Adams County, easements for parcels within Adams County will be provided prior to construction. The applicant has agreed that the pipeline will remain outside the City of Thornton's future rights-of-way for Highway 7, 152nd Avenue, Holly Street, Quebec Street, and 156th Avenue. The applicant also agreed that all utility crossings occur at near 90-degree angles when possible and be constructed following the City of Thornton's approval.

Colorado Department of Public Health and Environment (CDPHE) (Exhibit 4.3)

- CDPHE provided the applicant with a list of state requirements that must be met. The applicant provided a response to CDPHE stating that they will provide documentation that a Construction Permit has been obtained if necessary and will provide documentation of APEN submittal to CDPHE prior to construction.

Colorado Division of Parks & Wildlife (Exhibit 4.4)

- The Colorado Div. of Parks & Wildlife provided comments to the applicant to provide guidance for pre-construction and construction phases with the intention of protecting burrowing owl and bald eagle populations. The applicant has incorporated these measures into the Development Agreement with Adams County.

E-470 Authority (Exhibit 4.5)

a. The E-470 Authority provided comments to the application regarding permitting and operational procedures for the construction and post-construction phases of the project. The development agreement requires the applicant to submit evidence to the County of the approved E-470 Public Highway Authority ("E-470") Pipeline Crossing Permit for the crossing of E-470.

Metro Wastewater Reclamation District (Exhibit 4.6)

- Metro Wastewater Reclamation District (MWRD) initially had concerns that the proposed pipeline may intersect or impact the District's Second Creek Interceptor project. The applicant provided reassurance to MWRD that the two projects will not intersect. MWRD provided no further comments after the applicant's response.

Xcel Energy (Exhibit 4.8)

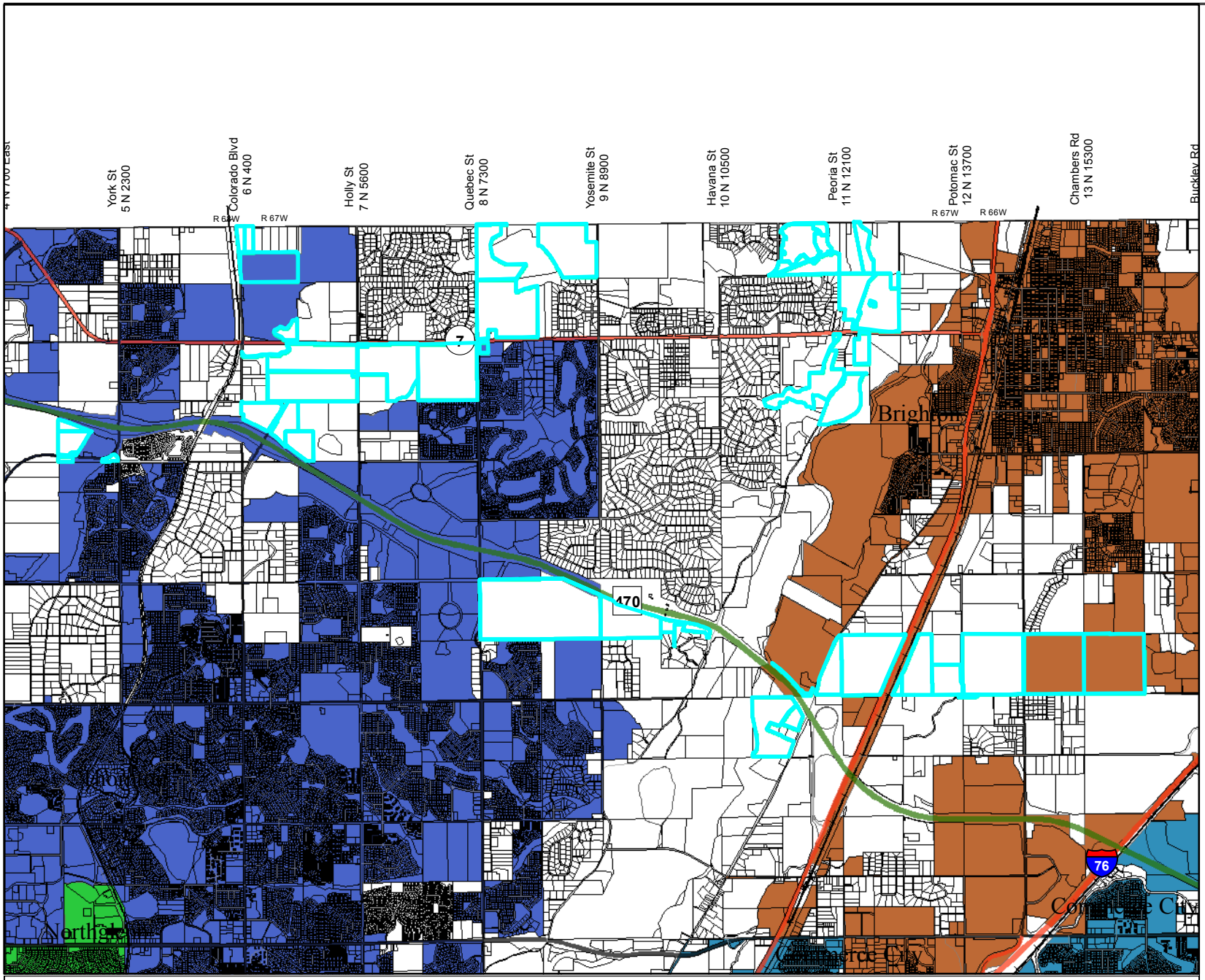
- Xcel Energy stated their company has electric transmission infrastructure that could be impacted by the proposed project. The development agreement requires the applicant to comply with Xcel Energy's requirements.

Responding without Concerns:

United Power (Exhibit 4.7)

Notified but not Responding / Considered a Favorable Response:

Adams County Sheriff
Amber Creek Metropolitan District
Brighton Fire District
Brighton 27J School District
Colorado Department of Transportation
Century Link
Comcast
Eagle Shadow Metro District
Heritage at Todd Creek Metropolitan District
North Metro Fire District
Regional Transportation District
Riverdale Peaks Metropolitan District
Thornton Fire District
Todd Creek Metro District #2
Todd Creek Village Metropolitan District



Legend

Cities

- Arvada
- Aurora
- Bennett
- Brighton
- Commerce City
- Federal Heights
- Lochbuie
- Northglenn
- Thornton
- Westminster

RCU2020-00004: Pioneer Produced Water Pipeline Project

Simple Map

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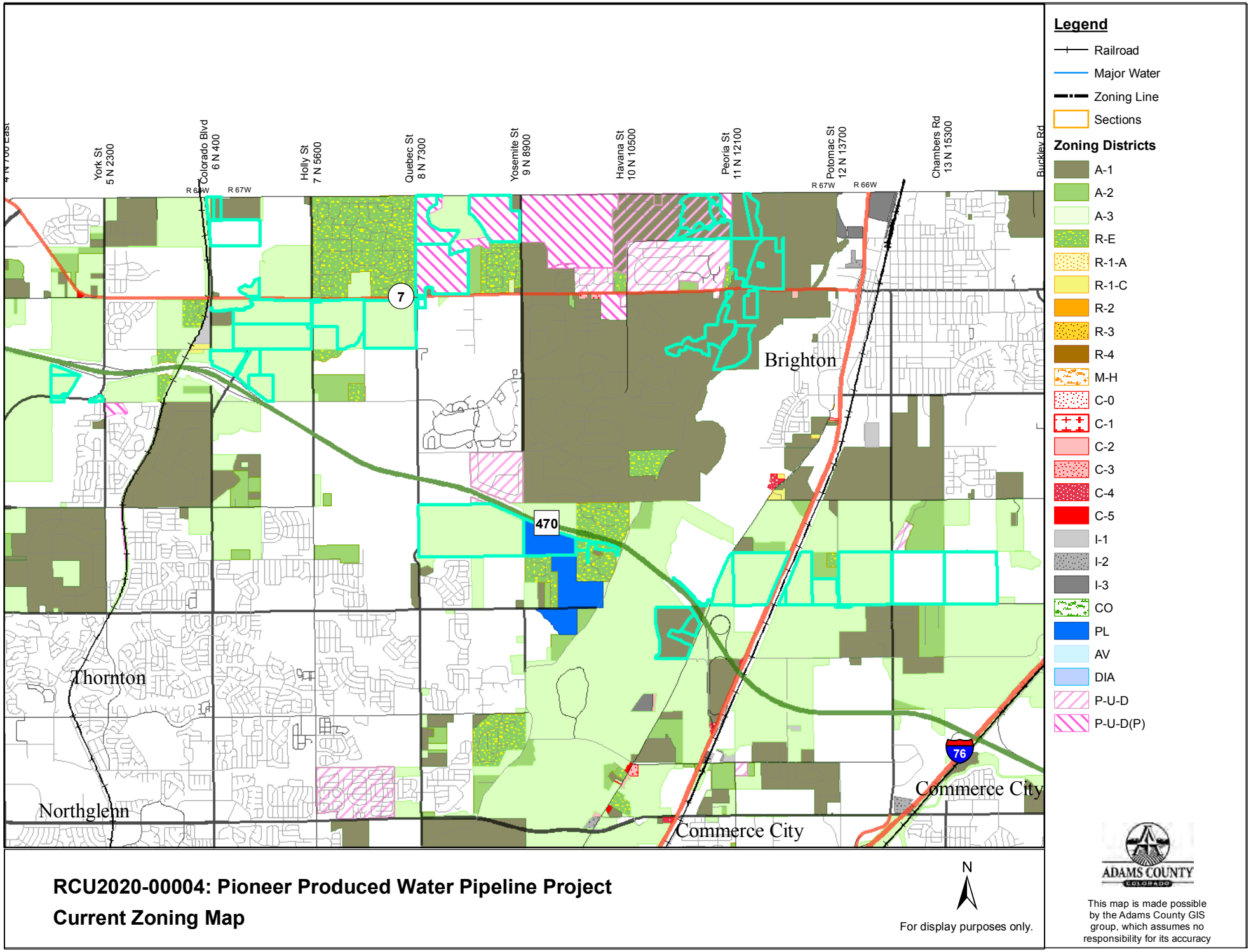
For display purposes only.

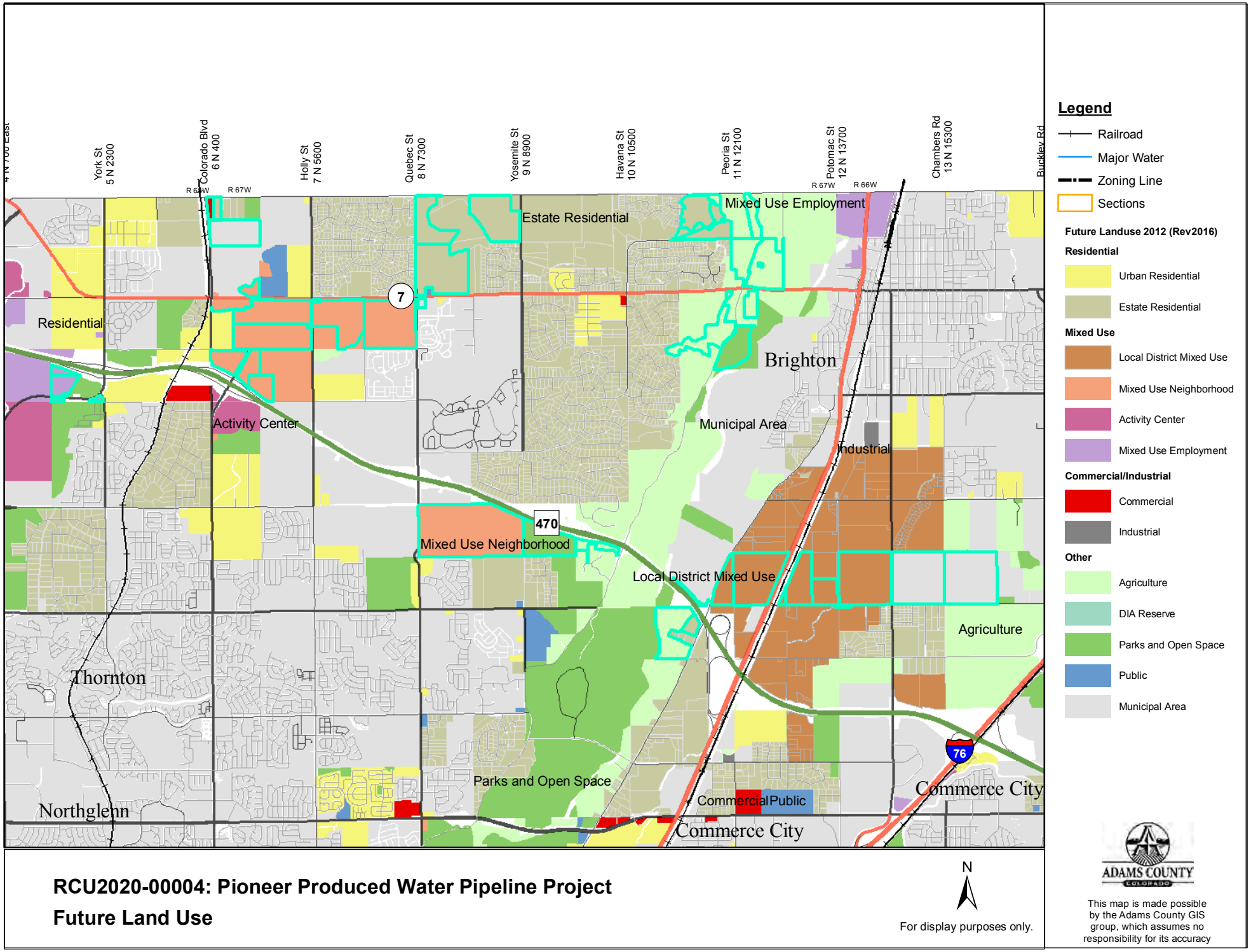
ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy



RCU2020-00004: Pioneer Produced Water Pipeline Project

Current Zoning Map



RCU2020-00004: Pioneer Produced Water Pipeline Project

Future Land Use

Pioneer Water Pipeline Project

Conditional Use Permit Application

February 2020

Prepared for:

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway, Brighton, CO 80601

Prepared by:

Pioneer Pipeline

Pioneer Water Pipeline, LLC, 600 17th Street, Suite 725, Denver, CO 80202

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List of Acronyms

AASI	Areas and Activities of State Interest
ACDSR	Adams County Development Standards and Regulations
BMP	Best Management Practice
CAAQS	Colorado Ambient Air Quality Standards
CDPHE	Colorado Department of Public Health and Environment
CDWR	Colorado Division of Water Resources
CFR	Code of Federal Regulation
COGCC	Colorado Oil and Gas Conservation Commission
CPW	Colorado Parks and Wildlife
CRS	Colorado Revised Statues
CUP	Conditional Use Permit
dBA	Decibels
EPA	U.S. Environmental Protection Agency
Expedition	Expedition Water Solutions Colorado, LLC
HDD	Horizontal Directional Drilling
HDPE	High-Density Polyethylene
IPaC	Information for Planning and Consultation
NAAQS	National Ambient Air Quality Standards
NHD	National Hydrology Dataset
NRCO	Natural Resources Conservation Overlay
NRHP	National Register of Historic Places
NWI	National Wetland Inventory
Pioneer	Pioneer Water Pipeline, LLC
Project	Pioneer Water Pipeline Project
ROW	Right-of-Way
SCADA	Supervisory Control and Data Acquisition
SWMP	Stormwater Management Plan
Tetra Tech	Tetra Tech, Inc.
USR	Use by Special Review
USACE	U.S. Army Corps of Engineers
USFWS	U.S. Fish and Wildlife Service
USGS	United States Geological Survey
WOTUS	Waters of the United States

1. Introduction

Tetra Tech, Inc (Tetra Tech), has prepared this Conditional Use Permit (CUP) application on behalf of Pioneer Water Pipeline, LLC (Pioneer), a subsidiary of Expedition Water Solutions Colorado, LLC (Expedition), for the proposed Pioneer Water Pipeline Project (Project). Tetra Tech prepared this CUP application per the requirements of Chapter 2—Application and Permitting Procedures in the Adams County Development Standards and Regulations (ACDSR), the CUP Checklist, and the requirements outlined in Chapter 6—Regulations Governing Areas and Activities of State Interest (AASI) as requested by the Adams County Department of Community Planning and Development during the Conceptual Review process (PRE2019-00065).

1.1 Document Organization

The permit application is organized in the same sequence as the submittal requirements in the CUP Checklist, AASI Checklist, and the Adams County Department of Community Planning and Development supplemental requirements. Exhibits provided with the application are listed in Table 1. Individual figures are listed in Table 2.

Table 1:
List of Exhibits Included with the Application

Exhibit	Content
A	Alignment Sheets
B	Natural Resource Conservation Overlay Report
C	Conceptual Review Preliminary Comments, Questions, and Responses
D	Typical Pipeline Trench and HDD
E	Expedition's Occupational Safety and Health Administration form 300: Summary of Work-Related Injuries and Illnesses
F	List of Parcel Owners
G	Neighborhood Meeting Notification, Meeting Materials, and Summary
H	Routing Narrative
I	Summary of Water Wells in the Vicinity of the Project.

Table 2:
List of Figures Included with the Application

Figure Number	Content[1]
1	Project Overview Map
2	Adams County Overview Map
3	Adams County Road Crossings Map
4	Adams County Zoning Map
5	Adams County Land Cover Map
6	Adams County Groundwater Aquifers Map

1 The information in this application is based on the pipeline route shown in these figures. The pipeline alignment is subject to change based on final engineering.

1.2 Project Description

The Project would consist of construction of approximately 48.5 miles of 4- to 12 inch-diameter high-density polyethylene (HDPE) produced water gathering pipelines and associated appurtenances in Adams and Weld counties, Colorado. Approximately 29.3 miles of pipeline would be located in Weld County, and 19.2 miles of pipeline would be located in Adams County. Approximately 12.3 miles will be in unincorporated Adams County. Within Adams County, the Project would traverse the municipalities of Brighton and Thornton. A Project Overview Map is provided as Figure 1 and an Adams County Project Map is provided as Figure 2. A detailed Project description is included in Section 2.3. Alignment sheets are included as Exhibit A.

1.3 Project History

Pioneer attended a Conceptual Review meeting with the Adams County Department of Community Planning and Development (PRE2019-00065) on July 22, 2019. The Adams County Department of Community Planning and Development advised Pioneer that the Project would be subject to the County's CUP review and approval. In addition, Pioneer was notified that the CUP application must also address and include submittal requirements for the AASI permit (Section 3) and a Natural Resources Conservation Overlay (NRCO) Review if the Project impacts up to an acre of land in the NRCO Review (Exhibit B).

Copies of the Adams County Department of Community Planning and Development Conceptual Review comments and the sections of this document that respond to those questions are included in Exhibit C. Table B-1 in Exhibit C also includes responses to the Development Conceptual Review comments and a reference matrix that details the specific section of this document where additional information can be found addressing each of the review comments.

1.4 Purpose and Need

The purpose of the Project is to allow more efficient pipeline transportation of produced water from oil and gas production facilities in Adams and Weld counties to Expedition's existing EWS #6 wastewater injection and disposal facility, thereby also significantly reducing truck traffic. Wastewater injection is a process of disposing of fluid underground into geologic formations that are capable of holding fluid. EWS #6 accepts water 24 hours per day and is able to dispose of 25,000 barrels (1,050,000 gallons) of water per day with the ability to expand.

Pioneer estimates that oil and gas production facilities generate approximately half as much water as product, meaning that that for every two barrels of product generated at an oil and gas production facility, an operator much dispose of one barrel of produced water. Without this Project, the operators of the oil and gas production facilities in Adams and Weld counties that would be connected by the proposed pipeline would transport the water generated during production to EWS #6 by truck (Illustration 1). Permits for the oil and gas facilities are described in additional detail in Section 2.3.2. Pioneer expects that the Project would have the following beneficial effects:

- **Traffic**: Construction of the Project would remove the equivalent of 5 million truck miles and over 50,000 truckloads per year on local roads.

- **Infrastructure**: The removal of these trucks from local road means fewer repairs and longer life for the streets and highways of the community.
- **Safety**: The removal of heavy truck miles from local roads would reduce the potential for traffic accidents.
- **Air Quality**: Removal of truck traffic reduces vehicle emissions and the quantity of particulates, ozone, odors, and other air pollutants in the atmosphere.
- **Sustainability**: Completion of the 100 percent electric-powered Project would reduce carbon emissions by 21,000 metric tons per year.
- **Community Revenue**: The Project anticipates providing approximately $500,000 per year in new tax revenue to the community, directly benefitting public schools among other public services.
- **Jobs**: The Project is expected to create 100 locally sourced jobs during construction, and approximately four permanent jobs once operational.

Pioneer has designed the Project to allow for expansion and additional capacity in the future if there is a need and economic feasibility to connect additional oil and gas facilities.

1.5 Regulatory Overview

Pioneer would ensure the Project obtains applicable land use, environmental, and construction permits, and would ensure permit conditions are met prior to the start of construction. Refer to Section 3.4.2 for additional information on permitting for the Project.

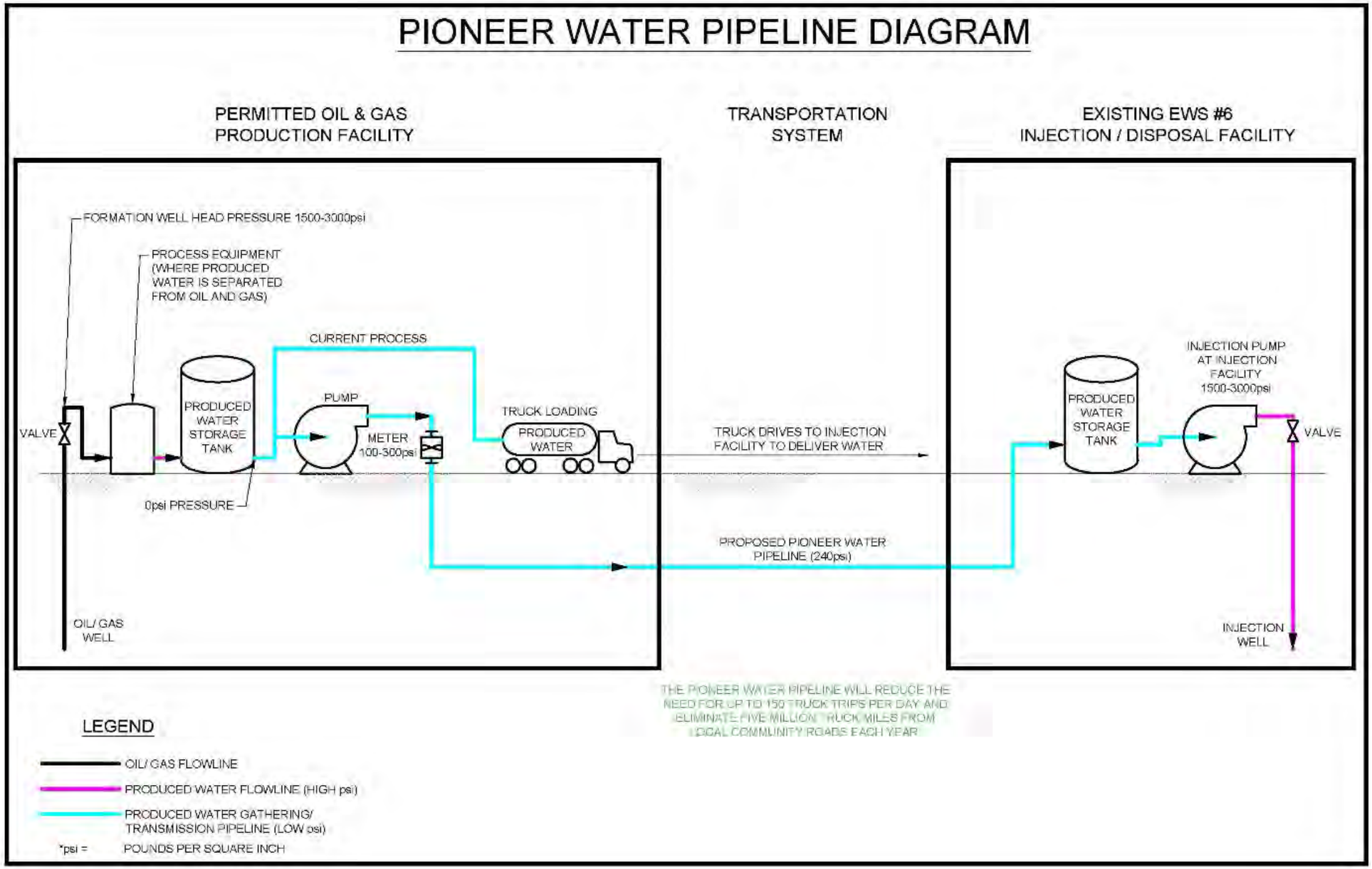

Illustration 1: Current and Proposed Method of Produced Water Transportation from Oil and Gas Production Facilities
Note: The Project would transport the produced water via pipeline; without the Project, the produced water would be transported by truck.

2. Conditional Use Permit Application Requirements

2.1 Development Application Form and CUP Checklist

The Adams County Development Application and AASI and CUP Checklists are included as part of this permit package as an attachment to the cover letter.

2.2 Application Fees

The $1,000.00 application fee for the CUP permit and the $360.00 Tri-County Health Department review fee are included with this application.

2.3 Written Explanation of the Project

2.3.1 Project Overview

The Project consists of construction and operation of approximately 19.2 miles of new produced water gathering pipelines in Adams County (Figures 1–2). Of the 19.2 miles in Adams County, approximately 12.3 miles are within unincorporated Adams County, and the remaining 6.9 miles are within the jurisdictional boundaries of the City of Brighton and City of Thornton. The City of Thornton and the City of Brighton would review the portions of the Project within municipal limits.

The Project is designed to transport produced water from 16 oil and gas production facilities located within Adams County and operated by Great Western Petroleum, LLC (see Section 2.3.2 for additional information about oil and gas production facility permits). An additional 29.3 miles of pipeline and connections to six additional oil and gas production facilities would be located within Weld County.

Produced water, also known as wastewater, is recovered as byproduct that is brought to the surface during oil and gas production. Oil, gas, and produced water leaves the well head at pressures up to 3,000 pounds per square inch (psi). The content of produced water varies with the formation where the water originates, but is generally high in salts with trace amounts of other minerals. After being brought to the surface, produced water is stored at the permitted oil and gas facilities in a storage tank. From the storage tank, the Project would transport the produced water via pipeline to Expedition's existing EWS #6 wastewater injection and disposal facility in Weld County. The pipeline would transport the produced water at a maximum pressure of approximately 240 psi until it reaches a storage tank at EWS #6. The maximum allowable pressure of the Pioneer Water Pipeline Project will be 333 psi. Expedition would increase the water pressure again at EWS #6 before it is injected underground.

2.3.2 Oil and Gas Production Facilities

Sixteen of the 22 oil and gas production facilities that the Project would connect are located within Adams County. The remaining six oil and gas production facilities are located in Weld County. The pipeline will be capable of transporting approximately 39.2 thousand barrels per day, of which an estimated 33 thousand barrels per day would come from oil and gas production facilities in Adams County at peak flow. Table 3 identifies the permit status for the Adams County oil and gas production facilities.

Table 3:
Oil and Gas Production Facility Permitting Jurisdictions and Permitting Status

Oil and Gas Production Facility Name	Permitting Jurisdiction	Permit Number/Status
Baseline	Adams County	USR2018-00010
B-Farm	Adams County	USR2017-00004
Brant	Adams County	USR2018-00011
Gus	Adams County	USR2018-00013
Ivey	Adams County	USR2016-00006
Kortum	Adams County	USR2018-00009
Ocho	Adams County	USR2016-00005
Rio	Adams County	USR2019-00001
Schaefer	Adams County	USR2016-00003
Seltzer	Adams County	USR2018-00002
Tollway	Adams County	USR2018-00005
Tower	Adams County	USR2018-00012
Sharp	Adams County	Application for USR in progress
Rico	Adams County	Application for USR in progress
Henderson	Adams County	Application for USR in progress
Prairie	Brighton	Located within the City of Brighton (Case File 18-00214)

USR = Use by Special Review

Great Western Petroleum, LLC would obtain Use by Special Review permits for the Sharp, Rico, and Henderson oil and gas production facilities from the Adams County Department of Community and Economic Development. Each Use by Special Review (USR) permit authorizes at least one produced water pipeline and associated appurtenances (pumps, valves, etc.) at the oil and gas production facility. Great Western Petroleum, LLC would assign the right to construct the produced water pipeline to Pioneer. Pioneer would construct the pipeline and appurtenances associated with the Project within the limits of the permitted well pad. This application therefore excludes Project facilities within the well pad. Pioneer would not construct the facilities at these locations until a USR permit has been issued to Great Western Petroleum, LLC.

2.3.3 Pipelines

The Project would consist of construction of approximately 48.5 miles of 4- to 12 inch-diameter HDPE produced water gathering pipelines and associated appurtenances in Adams and Weld counties. Pioneer is seeking a permanent easement for its pipelines that is approximately 10 feet wide as well as an additional 30 feet of temporary easement for pipeline construction.

The pressure and capacity of produced water pipelines is dependent on the distance from the pipeline origin (at each oil and gas production facility). The temperature of the produced water when it is extracted from the ground is high (close to formation temperature) and it cools and contracts as it travels through pipelines away from the well head. The Project pipelines would operate at an estimated 240 psi but may operate at a higher pressure depending on temperature. The maximum allowable pressure will be

333 psi. Pioneer would control pressure and monitor temperature using remotely operated valves located along the Project route. Illustration 1 in Section 1.4 of this document provides a graphical representation of the pipeline from the permitted oil and gas production facilities to EWS#6. Table 4 and Figures 1 and 2 provide the pipeline segment names, diameters, and total length of each within unincorporated Adams County. Brighton and Thornton would review and approve the remaining approximately 6.9 miles of pipeline in Adams County. Section 3.6 provides information on existing land use and zoning districts crossed by the Project.

Table 4:
Proposed Pipeline Segments within Unincorporated Adams County

Pipeline	Diameter (inches)	Length within Unincorporated Adams County (miles)
B-Farm Connection	6	0.15
Baseline Lateral	6	0.23
Gus Lateral	6	0.28
Henderson Lateral	4	0.11
Ivey Lateral	8	0.15
Kortum Lateral	8	0.14
North Adams Trunk	10	1.81
Ocho Connection	6	0.19
Pioneer Mainline	12	4.29
Rio Lateral	8	0.19
South Adams Trunk	10–12	3.6
Seltzer Lateral	4	0.08
Tollway Connection	6	0.12
Tower Lateral	6	0.92

To date, Pioneer has conducted a detailed routing effort to identify a preferred route. Pioneer is currently in the final stages of civil survey and anticipates finalizing landowner agreements and survey by the end of March 2020. The Project route may undergo minor route changes within the same parcels currently crossed by the Project as survey has been completed and landowner agreements are finalized. Pipeline construction often results in minor changes to the pipeline centerline within the permanent easement as a result of information gathered during construction. Pioneer would alert Adams County if information gathered in the field resulted in a change in the permanent and easement and would provide as-built spatial data identifying the pipeline centerline to Adams County upon completion of construction.

Pioneer's construction contractor would install the pipeline using mechanically excavated open-cut trenching techniques. The pipeline would be buried at a depth of 48 inches of cover or more. Pioneer's construction contractor would string pipe segments along the ditch line, fuse sections together using thermal fusion, and lower the pipeline into the open cut ditches. Each fusion joint would be logged by a data recorder with the results audited by qualified technicians, then lowered into the trench and backfilled. Upon completion of construction, the pipeline would be hydrostatically pressure tested to industry standards prior to operations.

Pioneer routed the Project to make use of existing rights-of-way (ROWs), property boundaries, and utility corridors associated with the oil and gas production facilities to the extent possible. Pioneer would obtain Adams County road ROW permits as required prior to construction, and the pipeline would only cross county road ROWs at or near a perpendicular angle. Pioneer has received preliminary approval to install pipelines within the E-470 Public Highway Authority ROW. Pioneer would obtain easements where the pipeline would cross private property. The pipeline would cross parcel 157123401001, which is owned by Adams County (reference Section 2.6). Additional information about the routing process is included in Section 3.3.2.

Pioneer proposes to cross state highways, county roads, railroads, and wetlands and streams and other existing infrastructure where practicable via horizontal directional drilling (HDD) to mitigate impacts to infrastructure and sensitive resources to the maximum extent practicable. Table 5 lists the county and state road crossings where the pipeline would be installed using HDD within Adams County. Section 3.11.5 describes Pioneer's commitment to avoiding impacts to wetlands and surface waters. The crossings listed in Table 5 are also depicted on Figure 3. Typical road and culvert crossings are provided in Exhibit D. Pioneer would repair or replace any Adams County infrastructure damaged during construction of the Project to pre-construction conditions.

Table 5:
Adams County Road Crossings

Crossing ID (Figure 3)	Street	Nearest Cross Streets[1]	Road Type
1	Colorado Blvd	E 156th Ave & Colorado Blvd	Local Road
2	Holly St	State Highway 7 & Holly St	Local Road
3	Monaco St	State Highway 7 & Monaco St	Local Road
4	Quebec St	State Highway 7 & Quebec St (South)	Local Road
5	County Road 2 - #3	County Rd 2 & Quebec St	County
6	County Road 2 - #4	County Rd 2 & Yosemite St	County
7	County Road 2 - #2	County Rd 2 & Lima St	County
8	County Road 2 - #1	County Rd 2 & Tucson St	County
9	Riverdale Rd #1	Riverdale Rd & State Highway 7 (South)	Local Road
10	Riverdale Rd #2	E-470 & Riverdale Rd	Local Road
11	E 136th Ave #1	E 136th Ave & Potomac St (West)	Local Road
12	E 136th Ave #2	E 136th Ave & Potomac St (East)	Local Road
13	Potomac St	E 136th Ave & Potomac St (South)	Local Road

2.3.4 Aboveground Appurtenances and Construction Laydown Areas

Construction of the pipelines would require an approximately 10-foot-wide permanent easement plus an additional 30-foot-wide temporary easement for a total construction corridor of 40 feet in width. Appurtenant aboveground facilities such as isolation valves, pumps, and cleaning tool launcher and receivers would be located at the existing oil and gas production facilities. Approximately five aboveground appurtenances consisting of three mainline valve sets and two cleaning tool launchers or receivers would be located on private easements within unincorporated Adams County. Pioneer would

site aboveground appurtenances outside of floodplains and outside of Adams County ROWs on private land. Easement negotiations for the aboveground locations are currently underway. Final locations of valves and other appurtenances would be provided to the Adams County Department of Community and Economic Development prior to public hearings.

Pioneer would design the project to be remotely operated through an automated supervisory control and data acquisition (SCADA) system. In the event of a leak or other unsafe condition, the SCADA system would automatically close valves and stop the flow of produced water.

Pioneer would use exiting laydown areas in Weld County and at EWS #6 to stage equipment and materials for Project construction. Pioneer does not anticipate using additional temporary workspaces in unincorporated Adams County besides those located along the pipeline route (see Exhibit A for the locations) that would be used to excavate trench, fuse pipeline segments, deliver the HDD equipment and pipe segments, excavate HDD entry and receiving pits, temporarily stockpile excavated soil from the pits, and serve as laydown for pipe segments. Pioneer's construction contractor would backfill, compact, and restore and revegetate the pipeline trench upon completion of the pipe installation. Following construction, the contractor would return temporary workspaces to pre-construction conditions.

2.3.5 Project Construction and Operation Safety

Pioneer is committed to safety and the Project would comply with all federal, state, and local rules and regulations to provide safe, reliable service. The Colorado Oil and Gas Conservation Commission (COGCC) would regulate the Project under the COGCC Series 1100 rules for flowlines (Series 1100 Rules), which references various technical standards and design, installation, construction reclamation, and operating/integrity management requirements. The Series 1100 Rules require Pioneer to submit a Flowline Report (Form 44) within 90 days of placing the Project into active status. Form 44 would include the location and specifications of the Project. The COGCC would have the authority to inspect the Project, and Pioneer would be required to notify the COGCC of the location of the Project within 30 days of construction.

Pioneer's parent company, Expedition, is rated Platinum by Independent Energy Standards, which place Expedition in the top 10 percent of similar companies for safety, environmental stewardship, and responsibility. Expedition's Occupational Safety and Health Administration's Form 300, "Summary of Work-Related Injuries and Illnesses," is included with this application as Exhibit E.

In the event of an emergency, the Project's SCADA system would automatically stop flow in the pipelines. Emergency response procedures would be described in an Emergency Response Plan for the Project, which can be provided to Adams County upon request.

2.3.6 Impact Avoidance and Minimization

Pioneer would design the Project to minimize impacts to sensitive resources and existing infrastructure such as utilities and roadways through the use of HDD. County and public road crossings would be constructed using HDD. Major construction activities for construction the Project would include staging materials, pipeline trenching and road crossing, pipeline installation, pressure-testing, backfilling, and restoration.

2.4 Construction Schedule

Pioneer proposes to begin construction activities in Weld County as early as March 2020 and in Adams County in fall 2020. Construction is expected to take approximately 6 months, with the Project fully in-service by the first quarter of 2021. Table 6 summarizes the Project's anticipated schedule in Adams County.

Table 6:
Project Schedule

Project Schedule Milestone	Approximate Milestone Date
Adams County Neighborhood Meeting	December 2019
CUP Application Filed with Adams County	February 2020
Anticipated Adams County Planning Commission Hearing	June 2020
Anticipated Board of County Commissioners (BOCC) Hearing	July 2020
Anticipated Development Agreement Signed by BOCC	July 2020
Begin Construction Adams County	July 2020
Pipeline Testing	Late Fall 2020
Project In-Service	First Quarter 2021

2.5 Site Plan Showing Proposed Development

An overview of the Project is included as Figure 1. An Adams County overview map is provided as Figure 2. Alignment sheets according to CUP Application standards showing existing and proposed improvements for the gathering system are provided as Exhibit A.

2.6 Proof of Ownership (Warranty Deed or Title Policy)

Pioneer would secure applicable easements and executed ROW agreements with landowners authorizing the right to construct, operate, and maintain the Project on privately and publicly owned properties. Pioneer would execute agreements with property owners and would record these agreements with the Adams County Clerk and Recorders Office prior to the commencement of construction activities. At this time, easements are in place for a majority of the Project route within Adams County. Pioneer would provide easements to Adams County for the Project prior to construction.

The pipeline would cross one Adams County-owned parcel (parcel #157123401001) via HDD, and Pioneer has contacted Adams County to obtain a license agreement from Adams County Real Property division. The License Agreement would not inhibit Adams County's continued use of this parcel as open space and South Platte River Trail.

Pioneer would obtain Adams County road ROW permits from Adams County as required prior to construction, and the pipeline would only cross county road ROWs at or near a perpendicular angle. A map depicting unincorporated Adams County road crossings is included as Figure 3. A list of parcels within unincorporated Adams County on which the Project would be located is included in Exhibit F.

2.7 Proof of Water and Sewer Services

2.7.1 Water Services

Pioneer's construction contractor would use water during construction for dust suppression, weed control, soil conditioning, and testing of the pipeline. Pioneer's construction contractor would obtain water under permit or delivered to the site as needed from local supplier and would not require a municipal water supply. Additional information is available in Section 3.4.4.

2.7.2 Sewer Services

The operation of the Project would not require water or sanitary services. Temporary sanitary facilities would be provided for construction workers along the pipeline ROW during construction.

2.8 Proof of Utilities (e.g., Electric, Gas)

A utility connection is not required to construct or operate the Project.

2.9 Legal Description

Exhibit A shows parcels crossed by the Project and their legal descriptions.

2.10 Certificate of Taxes Paid

Prior to commencement of construction activities, Pioneer would obtain applicable easements and executed ROW agreements for the pipeline. As easement holder, Pioneer is not responsible for the payment of property taxes on the parcels; they remain the responsibility of the landowner.

2.11 Certificate of Notice to Mineral Estate Owners/and Lessees

Pursuant to Colorado Revised Statues (CRS) Section 24-65.5-102 (2)(a), a pipeline does not constitute an "application for development" that would trigger the requirements of the Surface Development Notification Act, CRS Section 24-65.5-101; therefore, these requirements are not applicable to the Project.

2.12 Notice of Surface Development

Pursuant to CRS Section 24-65.5-102 (2)(a), a pipeline does not constitute an "application for development" that would trigger the requirements of the Surface Development Notification Act, CRS Section 24-65.5-101; therefore, these requirements are not applicable to the Project.

2.13 Supplemental CUP Information

2.13.1 Neighborhood Meeting Summary

Pioneer held a neighborhood meeting in accordance with the ACDSR from 5 p.m. to 8 p.m. on Tuesday, December 10, 2019, at Todd Creek Golf Club (8455 Heritage Dr., Thornton, CO 80602). The purpose of the neighborhood meeting was to provide the community a description of the Project and answer related questions from the attendees. A copy of the notification, neighborhood meeting materials, and a summary of the neighborhood meeting is provided in Exhibit G.

2.13.2 Solid Waste Transfer Station

Not applicable. The Project does not involve a solid waste transfer station.

2.13.3 Solid Waste Composting Facility

Not applicable. The Project does not involve a solid waste composting facility.

2.13.4 Scrap Tire Recycling Facility

Not applicable. The Project does not involve a solid tire recycling facility.

2.13.5 Inert Fill

Not applicable. The Project does not involve inert fill.

2.13.6 AASI Requirements

This permit application also includes AASI requirements as requested by the Adams County Department of Community Planning and Development during the Conceptual Review process. Refer to Section 3 of this application package.

3. Section 6-07-02. AASI Additional Supplemental Requirements

This CUP application also responds to requirements outlined in Section 06-07-02 under Chapter 6 Regulations Governing AASI and the AASI Checklist as requested by Adams County during the Conceptual Review process. The Project does not meet definitions of a Major New Domestic Water Treatment System, a Major New Domestic Sewage Treatment Systems, a major extension of an existing Domestic Water and Wastewater Treatment System, Major Facilities of a Public Utility, an Airport, Arterial Highways, Interchanges and Collector Highways, or Rapid or Mass Transit Facilities; therefore, this CUP application does not address Section 6-08 for additional submittal requirements related to AASI submittals for those project types.

3.1 6-07-02-01. Application Fee

A $1,000.00 application fee and the $360.00 Tri-County Health Department review fee are included as part of the CUP permit application. AASI permit fees are not applicable to the Project.

3.2 6-07-02-02. Information Describing the Applicant

The names, addresses, email address, fax number, organization form, and business of the Applicant, and if different, the owner of the Project.

Applicant Information

Pioneer Water Pipeline, LLC
Attn: Mr. Spence McCallie
600 17th Street, Suite 725
Denver, CO 80202
303-815-7064
smccallie@expedition-water.com

Project Owner Information

Pioneer Water Pipeline, LLC
Attn: Mr. Spence McCallie
600 17th Street, Suite 725
Denver, CO 80202
303-815-7064
smccallie@expedition-water.com

3.2.1 The names, addresses and qualifications, including those areas of expertise and experience with projects directly related or similar to that proposed in the application package, of individuals who are or shall be responsible for constructing and operating the Project.

Land Project Manager
Rhett Gore
Purple Land Management
700 17th Street #500
Denver, CO 80202
(303) 586-3167
rgore@purplelandmgmt.com

Permitting and Environmental Consultant:
Tetra Tech
John Heule, Project Manager
350 Indiana Street, Suite 500
Golden, CO 80401
Office: 303-980-3574
John.Heule@tetratech.com

Project Engineer
Mr. Jim McMangle
Spartan Engineering
12345 W Alameda Parkway
Lakewood, CO 80228

Project Surveyor
Jeff Weaver
Encompass Services
10901 W 120th Ave Suite 400
Broomfield, CO 80021

Construction Manager
The construction manager would be identified once the Project has been put out for bid in 2020.

Operations Manager
The operations manager would be identified once the Project has been put out for bid in 2020.

3.2.2 Authorization of Application by the Project Owner (If Different than the Applicant)

Not applicable.

3.2.3 Qualifications of Individuals Directly Related to the Proposed Project and Applicant's Financial and Technical Capability

Pioneer's parent company, Expedition, is a private-equity backed leading midstream produced water infrastructure company in the Rockies, and has expanded its revolving credit facility to $100 million. Cadence Bank served as lead arranger and administrative agent. The increased facility would fund Expedition's continued pipeline and facilities growth initiatives to service long-term, contracted customers in the Denver–Julesburg, Green River and Powder River Basins. The syndicated bank group also includes UMB, First Horizon and Woodforest.

Founded in 2013, Expedition has grown from a single disposal facility to a multi-basin company today with a capacity of more than 150,000 barrels a day. Expedition has constructed and manages 17 disposal wells and over 300 acres of evaporative pond capacity in Colorado and Wyoming. Expedition's commitment to build and maintain high-volume facilities enables it to grow with its customers while bringing tangible benefits to communities in which it operates.

Spence McCallie is the lead engineer for Pioneer Water Pipeline. Mr. McCallie has more than 10 years of experience constructing produced water pipelines and more than 20 years of overall pipeline construction experience. Pioneer has contracted Spartan Engineering to provide additional expertise in safety, engineering, and construction of the pipeline. Spartan Engineering is a global full-service engineering company with centuries of combined engineering, design, and construction management experience for pipelines.

3.3 6-07-02-03. Information Describing the Project

3.3.1 Detailed Plans and Specifications of the Project

Please see Section 2.3 for Detailed Plans and Specifications of the Project.

3.3.2 Descriptions of Alternatives

Pioneer considered and eliminated several alternative routes prior to selecting the preferred route. The routing process began by identifying the pipeline beginning points (permitted oil and gas production facilities) and the terminus (EWS #6). Alternative routes were then selected to minimize potential impacts while meeting the pipeline's objective. Refer to Exhibit H for descriptions of the alternatives.

3.3.3 Schedules for Designing, Permitting, Constructing, and Operating the Project.

Pioneer will design and construct the Project to avoid impacts to existing land uses and the public to the extent practicable. Section 2.4 provides an estimated milestone schedule for the Project. A final schedule for construction activities would be developed at a later date. The sections below provide additional detail on temporary workspaces and phasing for construction of the Project.

3.3.3.1 Survey, Permitting, Landowner Negotiations, Work Zone Preperation

The preliminary work phase consists of activities that cannot be performed at the same time as pipeline construction, such as civil survey, permitting, landowner negotiations, and work zone preparation.

3.3.3.2 Pipeline Construction

Pioneer is seeking permanent easement that is approximately 10 feet wide and an additional 30 feet of temporary easement for pipeline construction. The pipeline construction would consist of trenching, assembling the pipeline, and placing the pipeline within the open trench, backfilling the trench, and restoring the land according to landowner agreements. Typical construction drawings depicting typical trench section views and HDD are included in Exhibit D. The work zone may move up to 5,000 feet per day. In addition, this phase would include pipeline HDD installation. Refer to Section 2.3.5 for information regarding temporary workspaces and staging areas.

3.3.3.3 Surface Restoration

Upon completion of the construction, Pioneer's restoration contractor would remove construction materials and debris from the site. Temporary workspaces would be re-contoured to pre-construction conditions. Disturbed areas where vegetation was removed by construction activities to an extent that it caused potential soil erosion would be treated with seedbed preparation techniques, re-seeded with an approved seed mixture, and mulched as necessary during the planting season according to landowner agreements.

The Project would utilize a Stormwater Management Plan (SWMP) for implementation of best management practices (BMPs) to mitigate soil erosion, control noxious weeds, and revegetate disturbed areas. The Project intersects approximately 2.8 miles of area designated within the Adams County Stormwater Permit Area. Therefore, Pioneer will likely be required to obtain an Adams County Stormwater Quality (SWQ) Permit for Construction. Mature vegetation would be actively avoided, although some vegetation would be impossible to avoid and therefore would be replaced per the property owner's reasonable request with a like species. Vegetation in public ROW would be replaced to Adams County standards for revegetation within the public ROW. If pavement is damaged by open-cut crossings, it would be restored to meet or exceed pre-construction existing conditions and comply with local standards. Pioneer would repair or replace any Adams County infrastructure damaged by construction of the Project to pre-construction conditions.

3.3.3.4 Testing and Commissioning

The commissioning phase consists of testing and cleaning the pipeline and associated facilities. Before the pipeline is put into service, it would undergo hydrostatic pressure testing, i.e., filled with water and tested to verify the structural integrity and workmanship of the pipeline. Additionally, the test would ensure that no leaks are present.

3.3.4 Purpose and Need

Refer to Section 1.4—Purpose and Need, of this application.

3.3.5 Construction and Operation Conservation Techniques

Construction of the Project would incorporate mitigation measures that would minimize impacts to water quality, water use, existing land uses, surrounding communities, cultural resources, and the natural environment. Pioneer would use a SWMP for implementation of BMPs to mitigate soil erosion, control noxious weeds, and revegetate disturbed areas.

3.4 6-07-02-04. Property Rights, Permits and Other Approvals

Pioneer would obtain all necessary federal, state, and local permits and approvals and obtain property rights for construction and operation of the Project. A description of property rights, permits, and approvals required is provided in the sections that follow.

3.4.1 Property Rights

Documentation of property rights would be provided to Adams County Department of Planning and Development prior to construction. Refer to Section 2.5—Proof of Ownership of this application for more details.

3.4.2 Federal, State, and Local Permits and Approvals

Table 7 lists the permits approvals anticipated to be required for the Project and the status of obtaining these permits. Construction of the Project would be performed in accordance with the applicable requirements as stipulated in the permits.

Table 7:
Potential Permits and Approvals

Regulatory Authority	Permit/Approval	Status
Federal Approvals		
U.S. Army Corps of Engineers (USACE)	Federal Clean Water Act Section 404	Pioneer would hire a qualified contractor to perform wetland delineations in spring 2020, prior to construction. Pioneer would implement minor project layout adjustments, including minor route adjustments and the use HDD technology, to avoid unnecessary wetland impacts. If wetland impacts are unavoidable, Pioneer would obtain necessary permits and approvals from the USACE-Denver Regulatory Office prior to construction. The Project would likely qualify for a Nationwide Permit 12 for impacts related to linear transportation projects.
State of Colorado Approvals		
Colorado Department of Public Health and Environment (CDPHE), Water Quality Control Division	Stormwater Discharges Associated with Construction Activity Authorization to Discharge under the Colorado Discharge Permit System (COR400000)	Pioneer would apply for coverage under COR400000 at least 10 days prior to construction in accordance with CDPHE requirements. Pioneer would also manage stormwater through implementation of a SWMP in accordance with Part I.C. of COR400000.
	General Permit for Construction Dewatering Discharges to Discharge under the Colorado Discharge Permit System (COG070000)	Pioneer would apply for coverage under COG070000 at least 30 days before the anticipated date of discharge as needed.
Colorado Division of Water Resources (CDWR), Groundwater Information and Well Permitting	Temporary Dewatering Permit (GWS-62 form)	Pioneer would obtain prior to construction as needed.

Table 7:
Potential Permits and Approvals

Regulatory Authority	Permit/Approval	Status
CDPHE, Water Quality Control Division	Water Quality Certification under Section 401 of the Clean Water Act	Pioneer would obtain in conjunction with Section 404 permits. Under the Colorado 401 Certification Regulation, all nationwide permits are certified by statue and do not require a certification.
Colorado Department of Transportation, Region 1	Driveway/ Access Permit	Pioneer to apply for permit in spring 2020.
	Utility/Special Use Permit for crossings of state and federal highways	Pioneer to apply for permit in spring 2020.
CDPHE, Air Pollution Control Division	General Construction Permit –Land Development Projects (GP03) for land development including but not limited to land preparation such as excavating or grading, for residential, commercial, or industrial development, or oil and gas exploration and production	Pioneer would obtain prior to construction as needed.
	Air Pollutant Emission Notice for construction activity that disturbs 25 acres of continuous land or more and/or lasts 6 months or more in duration	Pioneer would obtain prior to construction as needed.
Local Approvals		
Adams County	Conditional Use Permit	Submitted to Adams County in February 2020.
	ROW Permit and Engineering Review for work in Adams County public ROW	Pioneer would apply for the ROW permit prior to CUP public hearings in spring 2020, and Pioneer would only cross county road ROWs at or near a perpendicular angle. New access to Adams County road ROW is not required for this Project. Pioneer does not anticipate obtaining an access permit from Adams County.
	Adams County Stormwater Quality (SWQ) Permit	The Project intersects approximately 2.8 miles of area designated within the Adams County Stormwater Permit Area. Therefore, Pioneer will likely be required to obtain an Adams County Stormwater Quality (SWQ) Permit for Construction.
Weld County	Right-of-Way Use Permit Application	Pioneer to apply for permit in spring 2020.
	Floodplain Development Permit	Pioneer to apply for permit in spring 2020.
E-470	Application for Pipeline or Wire Line – Crossing And/or Longitudinal for construction in, on, along, over, across, through or under E-470 property	Pioneer has received preliminary approval to install pipelines within the E-470 Public Highway Authority ROW based on in-person meetings with E-470 in fall 2019. Pioneer would apply for formal approval in spring 2020.
UPRR Railroad	Union Pacific Crossing/Encroachment Permit issued by the Union Pacific Railroad for utilities that cross or follow along the ROW	Pioneer to apply for permit in spring 2020.
City of Thornton	Special Use Permit[1]	Pioneer held a meeting with the City of Thornton on November 21, 2019, to discuss permitting requirements for the Project, and Pioneer provided additional information about the Project on February 14, 2020. To date, Thornton has not indicated whether the Project would require a land use permit. Pioneer would apply for the permit in March 2020 if required.

Table 7:
Potential Permits and Approvals

Regulatory Authority	Permit/Approval	Status
	Right-of-way Permit for road crossings.	Pioneer to apply for permit in spring 2020.
City of Brighton	Conditional Use Permit	Pioneer submitted an application in December 2019 and received comments on the application in early February 2020. Pioneer expects permit approval in late spring or early summer 2020.
City of Fort Lupton	Use by Special Review Permit	Pioneer to apply for permit in spring 2020.
Ditch Owners	Application for project review and crossing approval.	Pioneer to apply for permit in spring 2020.

1 Pioneer began conversations with Thornton on November 21, 2019, to determine whether City of Thornton permits are required for construction. At this time, Thornton is not requiring a land use permit.

3.4.3 Copies of Federal and State Consultation Correspondence and Mitigation Requirements and Environmental Impact Reporting

3.4.3.1 Federal and State Consultation Correspondence

Pioneer does not currently expect a federal or state approval is required for the Project as there is no federal nexus and there are no state consultation requirements at this time. The Project would be permitted through local jurisdictions. If the Project requires a federal permit (i.e., USACE) then the Project would coordinate and obtain the necessary permits and approvals prior to construction.

3.4.3.2 Mitigation Required by Federal, State, and Local Authorities

If mitigation measures are required as conditions of federal, state, or local permits issued for the Project, Pioneer would provide copies upon receipt.

3.4.4 Description of Water to Be Used by The Project

Dust suppression, weed control, soil conditioning, and hydrostatic testing of the pipeline would require water use during construction. The construction contractor would obtain appropriate permits for water appropriation and discharge, as required (Table 7). Water would be obtained from surface or groundwater under permit or delivered to the site as needed from local supplier as available. Approximately 680,000 gallons of water would be required for hydrostatic testing. Hydrostatic test water would be tested and disposed of according to the CDPHE General Permit for Construction Dewatering Discharges (COG070000) and returned to the source or injected at EWS #6 upon completion of hydrostatic testing. An additional 1.3 million gallons of water would be needed for dust suppression, weed control, and soil conditioning during construction.

3.5 6-07-02-05. Financial Feasibility of the Project

3.5.1 Estimated Construction Costs

The total estimated cost of the proposed Project is approximately $51 million. It is estimated approximately $27 million would be associated with construction in Adams County.

3.5.2 Contract or Agreement for Revenues or Services

The Project would be financed through private equity, with contractual agreements with local customers to provide minimum revenues. The details of contracts between Pioneer and its contractors to build the proposed Project have not been completed; contract details would be largely confidential.

3.5.3 Description of the persons or entity(ies) who shall pay for or use the Project and/or services produced by the Development and those who shall benefit from any and all revenues generated by it.

The purpose of the Project is to provide transportation of produced water from Great Western Petroleum, LLC oil and gas production facilities in Adams County to the existing injection facility at EWS #6. In addition, the proposed Project would reduce future truck use for wastewater transportation and provide safe and reliable service to Pioneer's customers. Pioneer anticipates that construction of this pipeline would reduce the need for up to 150 truckloads per day from Adams County roads and eliminate 5 million truck miles from local community roads each year of the of the predicted 50-year lifespan of the Project. Property tax revenue to Adams County generated by the proposed Project are estimated to be about $250,000 annually inclusive of all mill levy jurisdictions. Pioneer will pay about $319,000 in sales tax associated with construction of the Project.

The Project expects to directly benefit Great Western Petroleum LLC and its customers, Adams County, and indirectly benefit the public.

3.5.4 Cost of All Mitigation Measures Proposed for the Project.

The cost of mitigation, such as for HDD crossings of streams, roads, and drainages and avoidance sensitive resources, is included within the total estimated cost of the Project. The total cost for construction of the proposed Project in Adams County is approximately $27 million. Pioneer would bear 100 percent of mitigation costs.

3.5.5 Detailed description of Project Financing

Pioneer’s parent company, Expedition Water Solutions (Expedition) is a private-equity-backed leading midstream produced water infrastructure company in the Rockies, and has a revolving credit facility of $100 million. Cadence Bank (Cadence) served as lead arranger and administrative agent for the recent expansion of revolving credit. The increased facility would fund Expedition’s continued pipeline and facilities growth initiatives. The syndicated bank group also includes UMB, First Horizon, and Woodforest.

3.6 6-07-02-06. Land Use

3.6.1 Description of Existing Land Uses

Adams County zoning maps (11-21-2019) indicate the Project passes through six zoning classifications. The Project is overlaid on the Adams County Zoning classifications on Figure 4. Table 8 lists the zoning districts crossed by the Project and length in each zone. The Project meets the requirements of a Major Energy Facility, which is a conditional use in the zoned areas traversed by the Project.

Table 8:
Adams County Zone Districts Crossed by the Project.

Zone District	Zone Symbol	Length Crossed by the Project (miles
Agricultural-1 District	A-1	2.2
Agricultural-3 District	A-3	7.8
Planned Unit of Development	P-U-D	0.3
Proposed Planned Unit of Development	P-U-D(P)	1.2
Public Lands, Parks Open Space, and Facilities	PL	0.5
Residential Estate	R-E	0.5

Fifteen National Land Cover Database land cover classifications are crossed by the Project within Adams County (Figure 5): open water, developed open space, developed low intensity, developed medium intensity, developed high intensity, barren land, deciduous forest, evergreen forest, mixed forest, shrub/scrub, grassland/herbaceous, pasture/hay, cultivated crops, woody wetlands, and emergent herbaceous wetlands (Exhibit B, Figure 2).

3.6.2 Compliance with Provisions of Local Land Use Plans

The Imagine Adams County Adams County Comprehensive Plan (Adams County 2012a) outlines the County's objectives for future development within unincorporated areas of the County and in municipal growth areas. It establishes goals, policies, and strategies that would influence day-to-day decision-making regarding land use applications, capital improvement planning, and regional coordination efforts with other jurisdictions and agencies. Key goals, policies, and strategies related to the Project are discussed below.

Key Goal: Promote Coordinated and Connected Growth.

The Project would support the County's growing population and provide construction-related jobs. The Project would also serve to remove industrial traffic from County roads increasing safety within the County as it grows.

Key Goal: Protect the Health, Safety, and Welfare of Adams County's Inhabitants.

The Project would replace less efficient truck traffic with more efficient and safer pipeline transportation of produced water to the treatment facility. This would in turn reduce emissions from vehicles increasing the health and safety of residents within the County and near oil and gas production sites.

Key Goal: Foster Regional Collaboration and Partnerships.

Because the Project route passes through multiple municipalities and serving the oil and gas industry throughout the region, it would serve to further integrate the area and mitigate the impacts of the oil and gas industry throughout the region.

Key Goal: Reduce the Fiscal Impact of Growth

With the construction of the Pioneer pipeline, fewer trucks would be making daily trips on roads that serve the area, reducing the wear and frequency of repairs and maintenance, *and* decreasing costs to the County, especially as the population and industry within the County grows and changes.

Key Goal: Promote Economic Vitality.

The Project may restrict future land uses directly within the pipeline permanent easement but agricultural uses would continue to be allowed. The Project would not discourage high-quality commercial growth and economic development from occurring in areas surrounding the Project. The Project supports commercial growth and economic development in the surrounding area by ensuring a reliable and high-quality produced water transportation service that is essential to promoting a clean and safe environment for existing and future businesses in Adams County. The Project would also generate construction and operations-related jobs.

Key Goal: Preserve the County's Natural Resources.

The Project would not require additional water supply or use during operation. Pioneer is acquiring necessary permits for water service required during construction of the Project. See Sections 3.4.2, 3.11.3, and 3.11.4. The Project would reduce vehicle traffic, benefiting user experience in outdoor areas in the County, including parks, trails, and natural areas.

Countywide Policy: Transportation

The Project anticipates that construction of this Project would eliminate 5 million truck miles from local community roads each year of the predicted 50-year lifespan of the Project, which would provide a more sustainable transportation solution, preserve the integrity of the road system, and provide the safest and most reliable means of transportation through Adams County.

Countywide Policy: Economic Development

Construction and operation of the Project would generate economic benefits for the local economy in Adams County. The Project is expected to have a total estimated cost of $51 million; approximately $27 million of the Project cost would be allocated for the Adams County portion of the Project. At its peak, construction of the Project is expected to involve approximately 100 on-site jobs that would be filled primarily by local workers. Additional non-local workers are expected to commute from the Colorado Front Range Region or temporarily relocate to Adams and Weld Counties for construction of the Project. Estimates that construction wages will add $3.2 million to the Adams County economy and estimates the Project would result in hiring of four full-time employees for operations.

Adams County may also benefit from Project-related expenditures during Project operation. The Project would qualify as a targeted industry for employment within the County as specified by the Adams County Economic Development Corporation (Energy, Logistics, Wholesale Trade). The Project would allow for existing businesses in Adams County to expand and strengthen the labor workforce who live and work in the County.

Additional economic benefits would be derived from property tax. Based on assessed value, Pioneer estimates that property tax revenues generated by the Project would be approximately $500,000 annually. Taxing authorities that would benefit from property tax would include school districts, metropolitan districts, fire districts, library district, water and sanitation districts and other Adams County municipalities. These benefits would be generated each year and extend for the operating life of the Project.

Countywide Policy: County Fiscal Balance

Fiscal balance is a key element of the County Comprehensive Plan. The Comprehensive Plan states that "commercial and industrial development anywhere in the County would generate a positive fiscal benefit." Pioneer estimates property tax revenues generated by the Project are estimated to be approximately $250,000 annually.

Countywide Policy: Community Facilities and Services

The Project would be built to federal, state, and local quality and design standards. Pioneer is committed to safety, and would follow federal, state, and local regulations, design, and performance standards to provide safe, reliable service to Pioneer's customers.

Economic, environmental, and visual impacts due to construction and operation of the pipeline facilities were considered during the planning and development and siting of the pipeline facilities was designed to ensure minimization of impacts. The pipeline would be located underground and is not expected to interfere with existing or proposed agricultural use for more than one growing season.

Countywide Policy: Natural Resources and Resource Extraction

The Project supports commercial growth and economic development in the surrounding area by ensuring a reliable and produced water transportation service that is essential to existing companies in Adams County. The transport of produced water supports the extraction of natural resources contributes to the local economy, providing employment to County citizens and tax income to the government.

Pioneer has minimized its impacts to Adams County natural resources including wetlands, watersheds, floodplains, streams, and air quality. Section 3.11 summarizes potential Project impacts and mitigation measures taken by Pioneer to reduce impacts and avoid resources.

Countywide Policy: Agricultural Lands

Impacts to agricultural land would be minimal because the route primarily parallels existing ROWs. Furthermore, the pipeline would be located underground with the exception of approximately five appurtenances located within the permanent easements aboveground (reference Section 2.3.4) and is not expected to interfere with existing or proposed agricultural use.

Countywide Policy: Sustainability Initiatives

The Project anticipates that construction of this Project would eliminate 5 million truck miles from local community roads each year of the of the predicted 50-year lifespan of the Project, improving the operational efficiency of produced water transportation in and around Adams County by reducing energy

and fuel consumption and decreasing overall risk. Pipelines provide the safest and most reliable means of transportation or resources. Overall, the Project would reduce emissions, reduce potential conflicts between passenger vehicles and trucks, minimize the risk of spills, preserve the integrity of the road networks, avoid environmentally sensitive areas and abate impacts to property owner land by following section lines and existing ROWs.

Countywide Policy: Hazard Mitigation

Pioneer would prepare a site-specific Emergency Response Plan to establish emergency protocols for the produced water pipeline and associated facilities. Contractors and project personnel would be familiarized with the emergency procedures. In addition, construction contractors have standardized emergency protocol. Refer to Section 3.11.11.

3.6.3 Impacts and Net Effect of Project on Land Use Patterns

The Project would have no impact on the land use patterns within Adams County. Overall, the Project route would allow for agricultural practices and other zoned uses to continue within the pipeline easement, reduce environmental pollutants and risks to environmentally sensitive areas, minimize truck traffic and impacts to County roads and provide service local customers to boost local employment and contribute to the tax base.

3.6.4 Description of Surrounding and/or Impacted Communities

The Project is located primarily within unincorporated Adams County, with portions in Brighton and Thornton, CO and extends into unincorporated Weld County. Within unincorporated Adams County, the pipeline route passes on the edges of residential communities and developments, but remains adjacent to roadway ROWs, not going directly through residential communities. Otherwise, the project route passes primarily though agricultural uses.

3.6.5 Description of Cultural Resources

Refer to Section 3.11.10—Areas of Paleontological, Historic or Archaeological Importance.

3.6.6 Existing and Unique Agricultural Land in Area

The *Adams County Open Space, Parks and Trails Master Plan* (Adams County 2012b) identifies agricultural lands and local food production districts to preserve high-quality agricultural lands in the County. The Project would not impact these districts, proposed open space or park focus areas, nor would it impact associated land use goals. Refer to Sections 3.6.2 and 3.6.3 for additional information. The Project route and valve set locations would be along existing roads, property section lines, utility ROWs, and easements to minimize impacts to agricultural activities. Furthermore, the pipeline would be located to a depth of at least 48 inches and is not expected to interfere with existing or proposed agricultural use for more than one growing season.

3.7 6-02-02-07. Local Government Services

3.7.1 Existing Capacity of and Demand for Local Government Services

The Project would not have an adverse effect on the capability of local government to continue to provide services, nor would it exceed the capacity of service delivery systems. The Project would not require new permanent roads to complete construction of the Project or operations activities. Oversized loads would be permitted and approved by the County prior to using County roads. Effects on roads and transportation are discussed in Section 3.7.3 of this application.

In Adams County, the Project would be located within two school districts, Brighton School District 27J and Adams 12 Five Star School District. Impacts to these districts are not anticipated because the construction does not directly pass by any schools and is not expected to substantially impact bus routes.

In Adams County, the Project route is located within two fire districts, North Metro Fire Protection District and Brighton Fire Rescue District. Pioneer would consult with each to address any concerns the fire protection districts have. Neither fire protection districts have expressed any concerns to date.

As discussed in Section 2.3.5 and Section 3.11.11, Pioneer's Emergency Response Plan would include procedures and directions for emergency dispatch in the case of a pipeline emergency. The Project would not increase fire protection demands.

The Project is not expected to cause additional demand on law enforcement services. Interference or damage to the pipeline facilities would be detected by continuous electronic monitoring by Pioneer employees. In the case of an emergency, Pioneer would follow the Emergency Response Plan described in Section 3.11.11. Local law enforcement would be contacted as applicable based on the type and degree of such an emergency.

The existing infrastructure has the capacity to accommodate the activities associated with the construction, operations, and required maintenance of the proposed facilities and respective pipelines.

3.7.2 Impacts and Net Effect of the Project on Demand for Local Government Services

No new electric service would be required for the Project. Aboveground appurtenances would operate on solar power from on-site solar panels. Natural gas would not be necessary to construct the Project. Water use would be obtained from surface or groundwater under permit or delivered to the site as needed. A municipal source is not required.

The required electricity associated with the pipeline would not have an adverse effect on the capability of local government to continue to provide services, nor would it exceed the capacity of service delivery systems. The Project would not increase the need for police or fire protection services during construction and would be operated by Pioneer using appropriate security and emergency response procedures. No disruption to local utility services are expected to occur during construction or operation of the Project. It is not anticipated that the construction and operation of the Project would create additional demands for local government services.

3.7.3 Potential Effect of the Project on the Existing Transportation Network

As described in Section 2.12, the Project would not adversely impact the existing transportation network. Pioneer anticipates that construction of this Project would eliminate 150 truck trips per day and 5 million truck miles from local community roads each year of the predicted 50-year lifespan of the Project, which would reduce emissions, reduce potential conflicts between passenger vehicles and trucks, preserve the integrity of the road networks, reduce impacts to local infrastructure in conjunction with the goals of the Adams County Comprehensive Plan, and provide the safest and most reliable means of transportation of produced water through Adams County.

Pioneer would obtain an Adams County ROW crossing permit prior to construction, and the pipeline would only cross county road ROWs at or near a perpendicular angle. In any segment of the Project that is parallel to an Adams County ROW, the pipeline will be constructed a minimum of five (5) feet from the edge of the maximum future ROW width, as designated in the Adams County 2012 Transportation Plan.

Truck haul routes for material deliveries from off-site areas to the Project would utilize Colorado Boulevard, 160th Avenue, 168th Avenue, Quebec Street, U.S. 85, Riverdale Road, and 136th Avenue. None of these roads are expected to experience a significant impact from the delivery of materials during construction. Pioneer does not anticipate that the construction contractor would need to improve or close roads, intersections, or bridges to accommodate oversized truck deliveries to the Project.

Increases in traffic due construction trucks and other vehicles are expected to be negligible. Construction work hours are expected to be 7 AM to 7 PM Monday through Saturday. Construction may occur on Sundays and other hours outside the 7 AM to 7 PM timeframe on an as-required basis.

The total number and type of vehicles accessing the pipeline route during peak construction would include:

- Pickup trucks: 100 trips per day
- “Low boy” equipment transport trucks: 1-6 trips per week
- Pipe transport truck and trailer: 12 trips per week
- Bus/van: 1 trip per day

3.8 6-07-02-08. Financial Burden on County Residents

3.8.1 Description of the Existing Tax Burden and Fee Structure for Government Services

The Project is expected to generate economic benefits to Adams County during construction and after the Project has been placed in service because of an increase in assessed value and goods and services associated with the annual operation of these facilities. Pioneer estimates property tax revenue to Adams County generated by the Project would be about $250,000 annually.

3.8.2 Impacts and Net Effect of the Project on Existing Tax Burden and Fee Structure for Government Service

The Project would not create an undue financial burden on Adams County. The total estimated cost of the Project is estimated to be approximately $51 million. Approximately $27 million of the Project cost would be allocated for the Adams County portion of the Project. Pioneer estimates they will pay approximately $250,000 annually in property tax.

3.9 6-02-02-09. Local Economy

3.9.1 Description of Local Economy

Adams County had a total estimated population of 511,868 in 2018 (Table 9). The population in Adams County increased by an estimated 70,265 residents or approximately 16 percent from 2010 to 2018 and accounted for approximately nine percent of the total statewide population in 2018 (U.S. Census Bureau, 2019).

Table 9:
Population—2010

Geographic Area	Total Population1		2010 to 2018	
	2010	2018	Net Change	Percent Change
Adams County	441,603	511,868	70,265	15.9%
State of Colorado	5,029,196	5,695,564	666,368	13.2%
United States	308,745,538	327,167,434	18,421,896	6.0%

1 U.S. Census Bureau (2019)

According to the Colorado Department of Labor and Employment, the annual unemployment rate (not seasonally adjusted) was 2.4 percent in Adams County in October 2019, slightly higher than the statewide annual unemployment rate of 2.2 percent. Annual average unemployment rates during the recent economic downtown peaked in 2011, ranging from 9.2 percent statewide to 10.8 percent in Adams County (Colorado Information Marketplace 2019).

In 2017, the Adams County economy employed approximately 259,641 people. Employment has subsequently increased, with more people employed in 2017 than a decade earlier. Overall, Adams County represented 9.0 percent of the state's total employment in 2017 (Colorado Information Marketplace 2019).

In 2017, the most common industries in Adams County by number of employees are office and administrative support (40,255), management (25,958) and sales and related (24,532). These industries were the largest employers, collectively employing 34.9 percent of the Adams County workforce in 2017. The highest paying industries include computer and mathematical; architecture and engineering; computer; engineering and science; and law enforcement workers including supervisors and legal. (Data USA 2019).

In 2017, the average annual household income in Adams County was $64,087, approximately 2.1 percent lower than the state average of $65,458, and 12.2 percent lower than the Denver-Aurora-Lakewood Metro Area of $71,884 (Data USA 2019).

3.9.2 Impacts and Net Effects on the Local Economy and Opportunities for Economic Diversity

Construction and operation of the Project would generate economic benefits for the local economy in Adams County. The construction and capital spending phase would also generate economic benefits elsewhere in the state of Colorado and for the state as a whole.

The Project is expected to have a total estimated cost of $51 million, approximately $27 million of the Project cost would be allocated for the Adams County portion of the Project. At its peak, construction of the Project is expected to involve approximately 100 jobs during construction that would be filled primarily by local workers. Additional non-local workers are expected to commute from the Colorado Front Range Region or temporarily relocate to Adams and Weld Counties for construction of the Project. The Project is expected to result in four new full-time employees during operations.

Project-related expenditures for construction labor and materials would also support economic activity elsewhere in the local and state economy through the multiplier effect, because these initial changes in demand “ripple” through the local economy and generate secondary impacts. Industries likely to experience the greatest economic benefits include the construction sector and the professional and technical services sectors. Spending on local accommodation, food, and local services by construction workers temporarily relocating to the area is also expected to support income elsewhere in the local area. Construction-related impacts would be one-time impacts that would last for the duration of construction.

Adams County may also benefit from Project-related expenditures during Project operation. These impacts would be much smaller than those expected to occur during construction. Additional economic benefits would be derived from property tax, approximately $250,000 based on all mill levy jurisdictions. Authorities that would benefit from property tax would include school districts, metropolitan districts, fire districts, library district, water and sanitation districts, and other Adams County municipalities. These benefits would be generated each year and extend for the operating life of the Project.

3.9.3 Description of Jobs Created

Project construction is expected to directly employ approximately 100 construction-related workers during construction peak, with additional employment supported elsewhere in the local and state economy. The Project is expected to result in four new full-time employees during operations.

3.9.4 Income Potential from Jobs Created by or as a Result of the Project

The Project is expected to have a total estimated construction labor cost of $51 million, approximately $27 million associated with Adams County. As discussed in Section 3.9.2, construction of the Project would also support employment and income in other sectors of the local and state economy through the multiplier effect, because these initial changes in demand “ripple” through the local economy and generate secondary impacts. Spending on local accommodation, food, and local services by construction

workers temporarily relocating to the area is also expected to support income elsewhere in the local area. Construction-related impacts would be one-time impacts that would last for the duration of construction.

Project-related expenditures during operation would also support income in the local and state economy through the multiplier effect. These expenditures are expected to result in small but positive economic impacts that would occur annually over the operating life of the Project.

3.10 6-02-02-10. Recreational Opportunities

3.10.1 Description of Present and Potential Recreation Uses

Avoidance of recreational lands (parks) was a major consideration in the route selection process and the Project is not expected to be located within recreational areas. Because the produced water pipeline would be located underground with the exception of approximately five appurtenances (reference Section 2.3.4), located aboveground within the permanent easements, there is no anticipated impact to recreation resources. The pipeline will be installed using HDD at a near perpendicular angle across the Todd Creek Trail and South Platte River Trail. No hunting areas or recreational facilities are in the vicinity of the Project. The Project would not affect area fishing amenities.

3.10.2 Map of Locations of Recreational Uses

The pipeline crosses the Todd Creek Trail and the South Platte River Trail. No other recreational facilities or trails are located in the vicinity of the pipeline route.

3.10.3 Impacts and Net Effect of the Project on Present and Potential Recreational Opportunities

The Project would not degrade the quality or quantity of recreational opportunities and experiences within the County as the Project would be located underground with the exception of approximately five appurtenances located aboveground (reference Section 2.3.4) within the permanent easements. The pipeline will be installed using HDD to cross the Todd Creek Trail and the South Platte River Trail. No temporary or permanent impacts to these trails are expected.

3.11 6-02-02-11. Environmental Impact Analysis

This section addresses Section 6-20-01 of the Adams County Development Manual, which is an appendix that provides examples of the types of concerns that the BOCC would take into consideration in determining whether permit application complies with the approval criteria contained in Section 6-17 of the Adams County Development Manual.

3.11.1 Air Quality

3.11.1.1 Affected Airsheds

The Project is located within the Denver Metro/North Front Range airshed, which encompasses Adams County. Since 2002, the region has been designated as in attainment with all National Ambient Air Quality Standards (NAAQS) except ozone, for which the region is designated as nonattainment. As of January 22, 2020, the entire project is located within the “serious nonattainment area” for the 2008 eight-hour

ozone standard (84 FR 70897). Ozone levels tend to peak during the summer months when ozone formation is greatest in the presence of heat and sunlight.

3.11.1.2 Map and Description of the Ambient Air Quality and State Air Quality Standards of Affected Airsheds

The air pollutants for which U.S. Environmental Protection Agency (EPA) has promulgated NAAQS, and the Colorado Air Quality Control Commission has promulgated Colorado Ambient Air Quality Standards (CAAQS), summarized in Table 10.

Table 10:
Ambient Air Quality Standards and PSD Increments

Pollutant/Averaging Time	NAAQS (µg/m³)	CAAQS (µg/m³)	PSD Class I Increment (µg/m³)[1]	PSD Class II Increment (µg/m³)[1]
CO (carbon monoxide)				
1-hour[2]	40,000	40,000	—[3]	—[3]
8-hour[2]	10,000	10,000	—[3]	—[3]
NO_2 (nitrogen dioxide)				
1-hour[8]	188	188	—[3]	—[3]
Annual[4]	100	100	2.5	25
O_3 (ozone)				
8-hour[6]	137	137	—[3]	—[3]
$PM_{2.5}$ (particulate matter less than 10 microns in diameter)				
24-hour[7]	35	35	2	9
Annual[4]	12	12	1	4
SO_2 (sulphur dioxide)				
1-hour[9]	196	196	—[3]	—[3]
3-hour[2]	1,300	700	25	512
24-hour[2]	—[5]		5	91
Annual[4]	—[5]		2	20

PSD = Prevention of significant deterioration

µg/m³ = Micrograms per cubic meter

1 The PSD increment values serve information purposes only and do not constitute a regulatory PSD increment consumption analysis.
2 No more than one exceedance per year.
3 No PSD increments have been established.
4 Annual arithmetic mean.
5 The NAAQS for this averaging time for this pollutant was revoked by the EPA (2016).
6 An area is in compliance with the standard if the fourth-highest daily maximum 8-hour ozone concentrations in a year, averaged over 3 years, is less than or equal to the level of the standard.
7 An area is in compliance with the standard if the highest 24-hour PM2.5 concentrations in a year, averaged over 3 years, is less than or equal to the level of the standard.
8 An area is in compliance with the standard if the 98th percentile of daily maximum 1-hour NO2 concentrations in a year, averaged over 3 years, is less than or equal to the level of the standard.
9 An area is in compliance with the standard if the 99th percentile of daily maximum 1-hour SO_2 concentrations in a year, averaged over years, is less than or equal to the level of the standard.

Air pollutants emitted from construction of the Project would be transported by the winds in the area. CDPHE has provided a representative wind rose (Illustration 2) for the Fort St. Vrain Power Plant located near Platteville. This wind rose shows the typical wind patterns in the Front Range, which includes the Project. As shown in the illustration, winds generally follow a northeast-southwest orientation that aligns with the South Platte River.

3.11.1.3 Impacts and Net Effect on Air Quality during Construction and Operation

Impacts to air quality in the vicinity of the Project would be short term, transient, and limited to the construction period of the pipeline (approximately 6 months). Construction vehicles and equipment required for vegetation clearing, trenching, HDD installation and re-contouring may produce fugitive dust or exhaust emissions during the construction phase of the Project. Emissions of fugitive particulate matter (PM_{10} and $PM_{2.5}$) may be generated by construction equipment movement, pipeline trench excavation, and earthmoving activities. Engine exhaust emissions of NO_x, SO_2, CO, volatile organic compounds and particulate matter (PM_{10}, $PM_{2.5}$) would result from the operation of construction equipment.

Dust suppression would be conducted during construction. No air emissions are expected from the operation of the pipeline. As described in Section 3.4.2 (Table 7) Pioneer will submit a CDPHE APEN including a dust suppression plan prior to construction, and CDPHE would stipulate additional mitigation, monitoring and recordkeeping requirements for a minor source construction air permit if required.

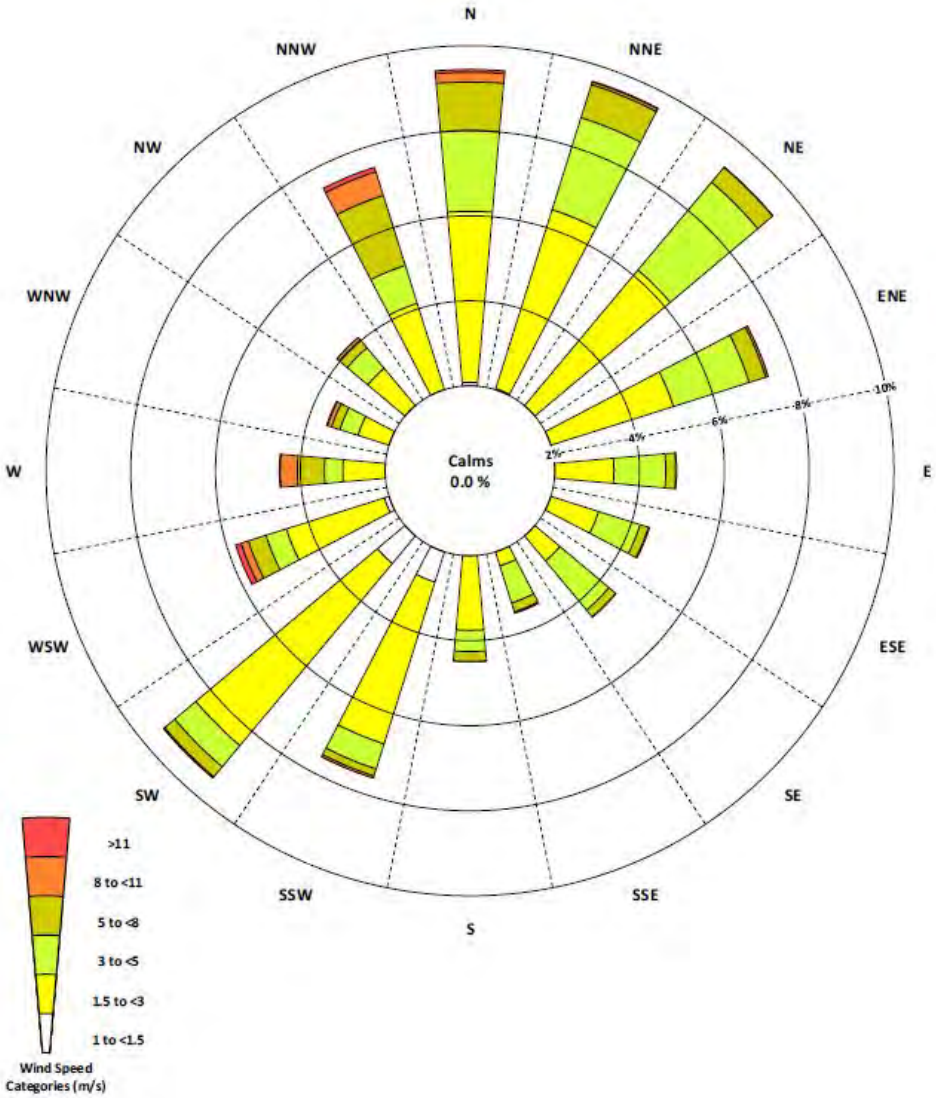

Illustration 2: Wind Frequencies by Speed and Direction, Platteville, CO

3.11.2 Visual Quality

3.11.2.1 Ground Cover, Vegetation, or Other Natural Features

The Project would be predominantly located adjacent to existing roadways and within grasslands, pastures, and areas of agricultural land use. The pipeline would be installed by means of open trenching or by HDD and would ultimately be buried underground with the exception of approximately three valve sets located within the permanent easement (Section 2.3.4). Pioneer would provide the final location of valve sets prior to public hearings for the Project.

Ground cover, vegetation, and other natural features vary throughout Adams County along the Project alignment. The entire Project is within the Flat to Rolling Plains Ecoregion, which is a subset of the High Plains Ecoregion, and consists of relatively flat terrain with few natural landscape features. The majority of the native vegetation in this area has been removed and replaced with crops such as wheat, grain, corn, and barley. Natural features crossed by the Project are limited to natural drainageways that traverse the landscape.

3.11.2.2 Description of Viewsheds, Scenic Vistas, Unique Landscapes or Land Formations

The Project would not affect high visibility corridors. Unique landscapes or formations that would be crossed by the Project were not identified, which consists of primarily grasslands/pastures and agricultural land use and light commercial development The Project would also not affect scenic vistas to the west towards the mountain ranges because the pipeline would be underground and there are no buildings associated with the valve sets.

3.11.2.3 Map and Description of Buildings, Structure Design, and Materials To Be Used for the Project

A map and description of the Project components, including structure design and materials to be used, are provided in Section 2.3.2.

3.11.2.4 Impacts and Net Effect of the Project on Visual Quality

Overall, the Project is not expected to affect visual quality. The pipeline would be installed by means of trenching or by HDD and ultimately would be buried underground and would be compatible with the surrounding area and harmonious with the character of the predominantly rural and agricultural land uses. The valve sets would be located within the permanent easements for the Project, which would be collocated with other linear ROWs including utility corridors and roadways. The valve sets would be visible from adjacent roadways and nearby residences. However, the valve sets would be similar to ancillary facilities associated with other oil and gas production facilities and would therefore not be out of character in the landscape setting.

Pioneer anticipates that pipeline construction would take approximately 6 months. Visual impacts would occur during construction when equipment, construction crews, and temporary construction staging areas are present; however, visual impacts would be short term as the pipeline would be installed underground and equipment would be removed once construction is complete.

3.11.3 Surface Water Quality

3.11.3.1 Map and Description of All Surface Waters

The Project is anticipated to cross surface water features mapped by the National Hydrography Dataset (NHD). The NRCO Report (Exhibit B) for the Project describes pipeline crossings of desktop-mapped surface water features within the NRCO. Pioneer would contract a qualified consultant to complete a wetland and other waters of the United States (WOTUS) delineation in spring 2020 to verify and delineate aquatic resources. Potential streams mapped by the NHD crossed by the Project in Adams County are summarized in Table 11.

Table 11:
Surface Water Crossings by the Project in Unincorporated Adams County

Crossing ID	Lateral Name	Stream Name (if available)	Latitude of Crossing[1]	Longitude of Crossing[1]
1	Pioneer Mainline	German Ditch	39.9858017	-104.9329987
2	Pioneer Mainline	German Ditch	39.9856987	-104.9329987
3	Pioneer Mainline	—	39.98550034	-104.9329987
4	Pioneer Mainline	—	39.98490143	-104.9329987
5	Pioneer Mainline	—	39.98590088	-104.9169998
6	Pioneer Mainline	Signal Ditch	39.98889923	-104.9029999
7	Pioneer Mainline	Signal Ditch	39.98590088	-104.9049988
8	N. Adams Trunk	Brighton Ditch	39.99409866	-104.8410034
9	N Adams Trunk	Brighton Ditch	39.9817009	-104.8460007
10	Tower Lateral	—	39.95660019	-104.9029999
11	Tower Lateral	—	39.95740128	-104.901001
12	S. Adams Trunk	Fulton Lateral Ditch	39.94319916	-104.8280029
13	Gus Lateral	—	39.95460129	-104.8850021
14	S. Adams Trunk	—	39.95510101	-104.8840027
15	S. Adams Trunk	Brantner Ditch	39.95199966	-104.8649979
16	S. Adams Trunk	—	39.94879913	-104.8600006
17	S. Adams Trunk	Third Creek	39.9435997	-104.8290024
18	S. Adams Trunk	Third Creek	39.94340134	-104.8280029
19	S. Adams Trunk	Third Creek	39.94329834	-104.8280029
20	S. Adams Trunk	Fulton Ditch	39.94319916	-104.8249969

Source: USGS (2018)

1 Based on preliminary desktop analysis. Field verification required to confirm actual site conditions.

Pioneer plans to install the pipeline using HDD for crossings of a majority of these features. If construction using HDD is not practicable, Pioneer would work under a USACE Nationwide Permit 12 and restore the crossing to pre-construction conditions when construction has been completed. Pioneer would not site aboveground appurtenances within the NRCO. Therefore, the Project would not result in permanent impacts to wetlands or other WOTUS.

3.11.3.2 Impact and Net Effects of the Project on the Quantity and Quality of Surface Waters

The Project would not have an adverse net effect on the capacities or functioning of streams in the impact area, or on the permeability, volume, recharge capability, and depth of aquifers in the surrounding area. Pioneer would obtain all necessary state, county, and local permits and comply with associated permit conditions (Section 3.4.2).

BMPs for sediment and erosion control to protect surface water would be accomplished through a combination of construction techniques, vegetation and revegetation, administrative controls, and structural features. BMPs that can be expected are listed in Table 12. Specific BMP types and selection criteria expected for various stages of construction are listed below in Table 13.

Table 12:
Non-Structural and Structural BMPs

Non-Structural BMPs		
Program Oversight	Construction Site Planning and Management	Good Housekeeping/ Materials Management
Construction Phase Plan Review Contractor Training and Certification Database Development and Maintenance	Timing of Projects Construction Sequencing Site Operator BMP Inspection and Maintenance Training Non-structural practices may include, but are not limited to a stabilized staging area, minimize initial pad site acreage, slope pad to the reserve put, wind erosion and dust control, temporary vegetation, permanent vegetation, mulching, geotextiles, sod stabilization, slope roughening, vegetative buffer strops, protection of trees, and preservation of mature vegetation. A water source may be used to abate dust and alleviate wind erosion.	General Construction Site Waste Management Emergency Response Plan
Structural BMPs		
Erosional Control	Sediment Control	Runoff Control
Berms Check Dams Culverts Culvert Protection Diversions Land Grading	Silt Fence Straw Bales Land Grading Vehicle Tracking Control Wattle	Berm Check Dam Culverts Culvert Protection Ditch and Berm

Table 13:
BMPs Types and Selection Criteria

Active	Completed	Final Stabilization
Pipelines and Storage Areas		
Berm Check Dams Culvert Protection Ditch & Berm Erosion Control Blanket Land Grading Mulches, with or without a tackifier Revegetation Silt Fence Vehicle Tracking Control	Berm Check Dams Culvert Protection Ditch & Berm Erosion Control Blanket Land Grading Mulches, with or without a tackifier Revegetation Silt Fence	Berm Culverts Diversion Ditch/Ditch and Berm Revegetation Mulches, with or without a tackifier

Table 13:
BMPs Types and Selection Criteria

Active	Completed	Final Stabilization
Straw Bales Wind Erosion Control Wattles	Straw Bales Wattles	
Access Roads		
Berm Check Dams Culverts Culvert Protection Ditch & Berm Erosion Control Blanket Land Grading Mulches, with or without a tackifier Revegetation Silt Fence Vehicle Tracking Control Straw Bale Wind Erosion Control Wattles	Berm Check Dams Culverts Culvert Protection Ditch & Berm Erosion Control Blanket Land Grading Silt Fence Straw Bale Roadside Ditch with Turnout	Berm Culverts Culvert Protection Ditch and Berm Gravel Surfacing Revegetation

3.11.3.3 Impacts and Net Effects of the Project Streambed Conditions

Streams and man-made waterways in the vicinity of the Project have been modified greatly as a result of historical and current agricultural practices. The Project would avoid perennial streams, rivers, or features through the use of HDD technology; however, other ephemeral and intermittent resources may be crossed by the Project alignment via open-cut trenching following USACE regulations and standards. Impacts to streams would be minor and temporary, the Project ROW would be returned to pre-construction conditions following construction. Downstream flow and aquatic life, if present, would not be impeded. Features would be returned to pre-construction contours, backfilled with the originally excavated material, and restored with salvaged vegetation in the minimum time necessary to conduct activities. BMPs would be used to avoid adverse impacts on minor ephemeral and intermittent streams, irrigation ditches, and any associated riparian features during the temporary disturbance of the features. As a result, the Project would not permanently affect the physical characteristics of the waterways crossed by the Project.

3.11.4 Groundwater Quality and Quantity

3.11.4.1 Map and Description of All Groundwater

The Project is located above the Denver and Arapahoe aquifers within the Denver Basin (Figure 6; CDWR, 2018). The Denver Basin (Denver, Arapahoe, and Laramie-Fox Hills aquifers) is a geologic formation in which aquifers lie on top of each other in layers with confining deposits separating the aquifers (USGS 2009). The Project is entirely within the CDWR South Platte Division (CGS 1992). Groundwater in areas crossed by the Project and vicinity generally flows towards the South Platte River.

3.11.4.1.1.1 Project Area Aquifers

The pipeline alignment within Adams County is located above the Denver, Arapahoe, and Laramie-Fox Hills aquifers of the Denver Basin.

3.11.4.1.1.2 The Denver Aquifer

The Denver aquifer underlies an area of approximately 3,500 miles and varies in thickness from a thin eroded edge at its outcrop/subcrop up to 1,000 feet. The Denver aquifer consists of a series of interbedded clay shale, clay, siltstone, and sandstone lenses. The sandstone and peddle compositions are typically volcanic. Carbonaceous material and coal beds are also common (CDNR, 2014).

Due to the fine-grained composition of the aquifer, wells commonly have yields of 50 to 150 gallons per minute. The wells are typically developed for domestic uses, although a number of municipal wells have been drilled on the western side of the basin where yields are higher. The Denver aquifer is separated from the underlying Arapahoe aquifer by an extensive clay/shale unit approximately 50 feet thick. The clay/shale interval serves as a hydraulic barrier between the aquifers (CDNR 2014).

3.11.4.1.1.3 The Arapahoe Aquifer

The Arapahoe aquifer is composed of interbedded conglomerates, sandstones, siltstones, and clay shales. The aquifer underlies an area of almost 4,700 square miles and is generally about 400 feet thick. For administrative purposes, the northern portion of the hydrogeologic unit is subdivided into an upper and lower aquifer that is separated by shale sequence ranging from 50 to 100 feet thick (CDNR, 2014).

Wells in the Arapahoe aquifer have the highest yield of the four aquifers, up to 800 gallons per minute. Consequently, the aquifer is used extensively to supply municipal water systems. Water quality is generally good, as evidenced by its use by Deep Rock Water to obtain water for bottling (CDNR 2014).

3.11.4.1.1.4 The Laramie-Fox Hills Aquifer

The lowermost of the four Denver Basin aquifers is the Laramie-Fox Hills aquifer, which underlies approximately 6,700 square miles and marks the areal extent of the basin for economic groundwater development. The aquifer is made up of both the marine sandstones of the Fox Hills and the overlying fluvial sandstones in the lower Laramie Formation. The Laramie-Fox Hills aquifer is generally between 250 and 300 feet thick and includes about 150 to 200 feet of fine- and medium-grained sandstone (CDNR, 2014).

Well yields of 350 gallons per minutes are common. The aquifer is extensively utilized throughout the basin for commercial development and less so for domestic use because wells within the aquifer are deeper over most of the basin. Both the Laramie-Fox Hills and Arapahoe aquifers are generally under artesian pressure (CDNR, 2014).

3.11.4.1.2 Colorado Division of Water Resources South Platte Division

Groundwater well information for wells permitted by the CDWR (2018) in the vicinity of the Project was reviewed to summarize groundwater conditions. A summary of information for water wells within 0.25 mile

of the Project is provided in Exhibit I. A map of water wells is included within Exhibit I, Figure I-1. Groundwater flow in the deeper bedrock aquifers is expected to be influenced by regional flow conditions.

The Project would not impact groundwater, directly contribute to groundwater recharge, or impact aquifer water levels. The pipeline would be located approximately 48 inches deep; therefore, no aquifer groundwater is expected to be encountered or impacted. If groundwater is encountered during trenching or HDD activities, dewatering methods may be employed, and the water would be pumped and discharged to undisturbed soils close to the pipeline trench.

Groundwater quality also would be protected through the implementation of a SWMP and through the implementation of waste management BMPs during construction. Waste from materials brought onto the construction site would be placed in appropriate containment and then removed for disposal/recycling to a licensed facility. No waste materials would be buried, dumped, or discharged to waters of the state. In addition, groundwater would not be utilized during construction activities or when the pipeline is operational. No subsurface water impoundment structures are proposed such as water storage systems or subsurface dams.

The potential for a pipeline failure release is remote. There may be areas that would require mitigation in order to restore areas affected by spills and/or repair the pipeline; however, the overall impacts are expected to be localized and minor.

Pioneer would prepare a site-specific Emergency Response Plan to establish emergency protocols for the produced water pipeline and associated facilities in the event of a release. Contractors and project personnel would be familiarized with the emergency procedures. In addition, construction contractors have their own standardized emergency protocol they would follow.

3.11.5 Wetlands and Riparian Areas

3.11.5.1 Map and Description of all Floodplains, Wetlands, and Riparian Areas To Be Affected by the Project

Using aerial imagery, USGS topographic maps and NHD, NWI, and Federal Emergency Management Agency floodplain information, potential aquatic resources intersected by the Project are shown in detail on sheet maps in Exhibit B. Table 14 summarizes wetland types crossed by the Project in unincorporated Adams County.

Table 14:
Wetland Types Crossed by the Project in Unincorporated Adams County

Wetland Type	Cowardin Type	Acreage within the Project Area[2]
Freshwater Emergent Wetland	PEM1A	0.03
Freshwater Emergent Wetland	PEM1C	0.55
Freshwater Pond	PUBF	0.17
Riverine	R2UBH	0.43
Riverine	R4SBC	1.33
Riverine	R5UBFx	0.04
Riverine	R5UBH	0.16
	Total	2.71

Table 14:
Wetland Types Crossed by the Project in Unincorporated Adams County

Wetland Type	Cowardin Type	Acreage within the Project Area[2]

Source: USFWS (2019)

Notes: PEM1A—Palustrine, Emergent, Persistent, Temporary flooded; PEM1C—Palustrine, Emergent, Persistent, Seasonally Flooded; PUBF—Palustrine, Unconsolidated Bottom, Semipermanently Flooded; R2UBH—Riverine. Lower Perennial, Unconsolidated Bottom, Permanently Flooded; R4SBC—Riverine, Intermittent, Streambed, Seasonally Flooded; R5UBFx—Riverine, Unknown Perennial, Unconsolidated Bottom, Semipermanently Flooded, Excavated; R5UBH— Riverine, Unknown Perennial, Unconsolidated Bottom, Permanently Flooded

2 Based on preliminary desktop analysis. Field verification required to confirm actual site conditions.

3.11.5.2 Description of the source of water interacting with the surface systems to create each wetland (i.e., side-slope runoff, over-bank flooding, groundwater seepage, etc.)

Potential wetland areas and other aquatic features were identified during a preliminary desktop review. The majority of the features crossed by the Project are anticipated to be fed by surface water runoff, high groundwater table, and/or seepage from irrigation ditches and canals.

3.11.5.3 Impacts and Net Effect of the Project on the Floodplains, Delineated Flood Hazard Zones, Wetlands, and Riparian Areas

The proposed Project would intersect riparian areas associated with the South Platte River in two locations, a narrow riparian area along Big Dry Creek and a small riparian area following an unnamed stream north of German Ditch.

At the time of this application, the Project study area intersects 86 suspected emergent wetlands within Adams County; however, field verification would be required to confirm the location and extent of wetlands intersected by the Project. No forested wetlands or riparian areas would be crossed by the Project as delineated by the USFWS NWI or observed on aerial imagery (Table 14). In addition, pipeline installation is generally considered a temporary impact, as wetland features would be returned to pre-construction contours and revegetated upon completion of construction. Pioneer would contract a qualified consultant to complete a wetland and other WOTUS delineation in spring 2020 to verify and delineate aquatic resources. HDD technology would be utilized to avoid surface impacts to perennial features and any other sensitive resources identified. Pioneer would complete appropriate consultation and/or permitting with the USACE-Denver Regulatory Office and obtain all authorizations for impacts to potential WOTUS as needed; however, based on a preliminary review of resources present and construction plans and methodology, written authorization does not appear to be necessary.

The Project intersects Federal Emergency Management Agency 100-year floodplains associated with Big Dry Creek, Todd Creek, an unnamed tributary to Todd Creek, and the South Platte River. The Project would temporarily impact floodplains. These impacts would be restored to the original contours once construction is completed and therefore, the project would not result in impacts to 100-year floodplains. Reference Exhibit B, Figure 3 for a map of FEMA 100-Year floodplains crossed by the Project.

3.11.6 Terrestrial and Aquatic Animals and Habitat

3.11.6.1 Map and Description of Terrestrial and Aquatic Animals

A desktop analysis was performed to identify wildlife habitat in the area of the Project (Exhibit B). The shortgrass prairie in Colorado was once inhabited by massive herds of free-ranging bison and pronghorn as well as huge prairie dog colonies, deer, and elk and top predators including gray wolves and grizzly bears. Currently, the most abundant animals on the prairie are domestic cattle, coyotes, and prairie dogs. Pronghorn still inhabit Colorado's prairies, although in reduced numbers. Species of conservation concern that still inhabit native prairie habitats in Colorado include burrowing owl, ferruginous hawk, mountain plover, McCown's longspur, chestnut-collared longspur, and long-billed curlew as well as northern pocket gopher, ornate box turtle, massasugua rattlesnake, and Texas horned lizard (NatureServe 2018). Deer, turkey, pheasant, and dove are the common game wildlife in the vicinity of the Project. It is not anticipated that construction and operation would have a more than a temporary and negligible impact on game and non-game wildlife, livestock, and other animals.

3.11.6.2 Description of Stream Flows and Lake Levels Needed to Protect the Aquatic Environment

The Project would not impact stream flows or lake levels. Perennial water features would be crossed by HDD with no disturbance to the bed or bank. Other features would be crossed by open-cut trenching, however, downstream flow and aquatic life, if present, would not be impeded. Features would be returned to pre-construction contours, backfilled with the originally excavated material, and restored with salvaged vegetation in the minimum time necessary. All surface water crossings necessary for the Project would adhere to state requirements for the use of surface waters as regulated by the CDWR. The aquatic environment would not be adversely impacted by the Project following restoration.

The CDPHE Water Quality Control Division's General Permit for Stormwater Discharges from Construction Activities allows for dewatering of groundwater and stormwater to undisturbed soils to allow for infiltration on the site. It is not anticipated that dewatering activities would be required during the Project. However, if dewatering becomes necessary, groundwater and/or stormwater may be pumped from excavations or trenches to the ground surface for containment, infiltration, or evaporation. If necessary, the location of pumping and discharge of the groundwater or stormwater would be marked on the site plan prior to the start of pumping activities. If it becomes necessary to contain and sample groundwater prior to discharge or pump groundwater off site or into a waterway or storm sewer, a groundwater discharge permit (Colorado Discharge Permit System) would be obtained from the state prior to engaging such activities. It is not expected that any such dewatering activities would impact stream flows or lake levels.

3.11.6.3 Description of Threatened or Endangered Animal Species and Habitat

Please reference Exhibit B for information regarding threatened and endangered animal species and habitat.

3.11.6.4 Map and Description of Critical Wildlife Habitat and Livestock Range

Please reference Exhibit B for a map and description of wildlife habitat. The Project is not expected to affect livestock as the pipeline would be located underground with the exception of three aboveground valve sets located within the permanent easement for the Project.

3.11.6.5 Impacts and Net Effect of Project on Terrestrial and Aquatic Animals, Habitat and Food Chain

No critical wildlife habitat for federally listed species is present in the immediate vicinity of the Project and no such habitat is mapped by state or local agencies. The relative size of the Project and primarily temporary nature of disturbance is not anticipated to impact the food chain of area wildlife.

The Project is located in a predominantly rural agricultural area with little native wildlife habitat and ideal grassland habitat. Project construction (pipeline) would cause temporary disturbance of approximately 190 acres of agricultural land. Native shortgrass prairie is not anticipated at a measurable quantity with the Project boundaries. Under expected conditions, it is not anticipated that construction and operation within the Project would have a more than a temporary and negligible impact on migration routes, calving areas, summer and winter range, game and non-game wildlife, livestock, or other animals. It is possible that the Project may be used for opportunistic feeding for wildlife; however, the Project ROW does not offer suitable habitat distinguishable from the rest of the surrounding properties. The primary effect is likely to be temporary wildlife avoidance of the construction zone due to noise, vibration, and human presence during one growing season. However, impacts to vegetation and wildlife would be minimized using BMPs and mitigation measures, performance of appropriate pre-construction surveys, avoidance of sensitive habitat areas, and using HDD techniques to avoid disturbance to sensitive resources.

Quantitative impacts, albeit temporary and minimal, to aquatic resources cannot be estimated until field investigations are conducted to confirm and delineate features. Minimal and temporary impacts to the aquatic environmental may occur during excavation, pipeline placement, and backfill. BMPs would minimize erosion and sedimentation. Intermittent and ephemeral water features would not be dewatered (in the event water is present) during pipeline construction and local water sources would not be utilized for construction. The pipeline would be installed via HDD under all perennial streams. All water features would be restored to pre-existing contours; therefore, no stream flows, lake levels, or spawning streambeds would be permanently impacted by the Project.

A raptor nest survey for the entire Project (not limited to the NRCO areas) conducted in January 2020 within 0.5 mile of the Project identified 32 raptor nests during the survey (Attachment 1). Twenty raptor nests were observed within the 0.5-mile buffer of the Project including one bald eagle nest (Nest 023), two red-tailed hawk nests (Nests 0018 and 009), and 17 nests with unknown species determination. The unknown nests were small and are unlikely to be used by eagles. Nest 032, a bald eagle nest located within the 0.5-mile buffer of the Project according to data provided by CPW, was not found by the biologist during the survey.

CPW recommends a seasonal non-encroachment buffer of 0.5 mile from October 15 to July 31 for active bald eagle nests and 0.3 mile from February 15 to July 15 for active red-tailed hawk nests. As the raptor nest survey was conducted early in the year (January 2020), only a few nests were active. Additional raptor nest surveys should be conducted if construction activities are expected to occur prior to August 31, 2020, when the raptor breeding season ends. The Project will adhere to the CPW recommendations to avoid potential harassment of raptors during construction.

3.11.7 Terrestrial and Aquatic Plant Life

3.11.7.1 Map and Description of Terrestrial and Aquatic Plant

A desktop analysis was performed to identify terrestrial and aquatic plant habitat in the area of the Project and field reconnaissance is proposed for late summer/early fall 2018. The results of those studies were reported in Exhibit B and are summarized in this section.

The Project intersects five vegetation types (CPW 2013):

- *Agriculture* is controlled use for production of biological products.
- *Irrigated Ag* is irrigated crops and fields.
- *Grass*/*Forb Mix* is rangeland co-dominated by grasses and forbs.
- *Grass Dominated* is rangeland dominated by annual and perennial grasses.
- *Rangeland* is a mix of non-native and native grasses, grass-like plants, forbs, or shrubs suitable for grazing or browsing use.

The Project in Adams County is located entirely with the one Level III ecoregion, High Plains (25) as mapped by the EPA. Within the High Plains, the Project is located within the Flat to Rolling Plains (25d). Dryland farming is extensive, with areas of irrigated cropland scattered throughout the ecoregion. Winter wheat is the main crop, with a smaller acreage in forage crops. Land use is predominantly rangeland in contrast to the cropland or mosaic of cropland and rangeland of surrounding ecoregions. Blue grama-buffalograss is the natural shortgrass prairie type with blue grama (*Bouteloua gracili*), buffalograss (*Bouteloua dactyloides*), threadleaf sedge (*Carex filifolia*), fringed sage (*Carex crinita*), Junegrass (*Koeleria* spp.), and western wheatgrass (*Pascopyrum* spp.) the most common species expected (Chapman et al. 2006).

Desktop analysis suggests that variations of Palustrine, Emergent or Palustrine, Scrub/Shrub wetlands may be crossed by the Project. If wetland communities are present, the wetland vegetation anticipated include cattail (*Typha* spp.), rough cocklebur (*Xanthium strumarium*), plains switchgrass (*Panicum virgatum*), barnyard grass (*Echinochloa* spp.), bulrushes (*Scirpus* spp.), rushes (*Juncus* spp.), and sedges (*Carex* spp.), willows (*Salix* spp.), alder (*Alnus* spp.), peach-leaf willow (*Salix amygdaloides*), and cottonwoods (*Populus* spp.).

Listed Plant Species: Three federally listed plant species, Colorado butterfly plant, Ute ladies-tresses and western prairie fringed orchid, were considered for an effects analysis. As described in Exhibit B, it is unlikely that the identified federally listed species would occur in areas crossed by the Project.

Noxious Weeds. Noxious weeds, as identified based on the Colorado Noxious Weed Act (35-5.5 CRS) and the Adams County Noxious Weed Management Plan and Enforcement Policy, are expected to be encountered because the majority of the Project is located within recently disturbed areas, near roadways, and in fallow fields. Because field investigations are pending (anticipated late summer/early fall 2018), the specific composition and density of noxious weeds cannot be identified at this time. Following field assessment, a specific weed management plan would be prepared as necessary. The Project would comply with the Adams County Noxious Weed Management Plan and Enforcement Policy.

3.11.7.2 Impacts and Net Effect that the Project on Terrestrial and Aquatic Plant Life

Based on the Project location and lack of suitable plant and wildlife habitat, it is not anticipated that any formal field surveys for federally listed plant species would be necessary. The State of Colorado does not have a sensitive species list for plants, and no formal protections are in force. Pioneer has begun informal consultation with USFWS and CPW to identify any issues that need to be addressed with development of the Project. No issues with effects to terrestrial or aquatic plants have been identified to date.

Field reconnaissance is pending and proposed for late summer/early fall 2018. Findings from the survey would provide the necessary data to prepare an appropriate weed management and revegetation plan as needed. Field data would ensure the plan would address the actual site conditions and propose appropriate actions for compliance with county and state regulations. A preliminary reclamation plan for the project, which addresses BMPs for the minimization of weed species, has been prepared as part of the SWMP.

Overall, the Project pipeline would cause temporary disturbance of less than 59.5 acres of agricultural/rangeland within unincorporated Adams County. Native shortgrass prairie is not anticipated to be present at a measurable quantity with the Project boundaries. Quantitative impacts, albeit temporary and minimal, to aquatic resources cannot be estimated until field investigations are conducted to confirm and delineate features. Mitigation measures would be performed if required to replace vegetation disturbed during construction of the Project.

3.11.8 Soils, Geologic Conditions, and Natural Hazards

3.11.8.1 Map and Description of Soil, Geologic Conditions, and Natural Hazards

3.11.8.1.1 Soils

NRCS-mapped soil types crossed by the Project are summarized in Table 15. Generally, the soils crossed by the Project are non-hydric, gently to moderately sloping, well drained loams (NRCS 2020).

Table 15:
Summary of Soil Types

Soil ID	Soil Series	Slopes	Flooded	Ponded	Drainage	Permeability	Hydric
AdB	Arvada loam	0–3%	None	None	Well drained	Rapid	No
AsB	Ascalon sandy loam	0–3%	None	None	Well drained	Very Rapid	No
AsC	Ascalon sandy loam	3–5%	None	None	Well drained	Very Rapid	No
AsD	Ascalon sandy loam	5–9%	None	None	Well drained	Very Rapid	No
BoD	Blakeland loamy sand	3–9%	None	None	Somewhat excessively drained	Very Rapid	No
DaA	Dacono loam	0–1%	None	None	Well drained	Very Rapid	No
DaB	Dacono loam	1–3%	None	None	Well drained	Very Rapid	No
Gr	Gravelly land-Shale outcrop complex	N/A	None	None	Excessively drained	Very Rapid	No
Lv	Loamy alluvial land, gravelly substratum	N/A	Occasional	None	Somewhat excessively drained	Very Rapid	Yes; 5%

Table 15:
Summary of Soil Types

Soil ID	Soil Series	Slopes	Flooded	Ponded	Drainage	Permeability	Hydric
Lw	Loamy alluvial land, moderately wet	N/A	Occasional	None	Somewhat poorly drained	Very Rapid	Yes; 6%
MISLD	Gravel pits	N/A	None	None	N/A	Very Rapid	No
NlA	Nunn loam	0–1%	None	None	Well drained	Rapid	No
NuA	Nunn clay loam	0–1%	None	None	Well drained	Rapid	No
NuB	Nunn clay loam	1–3%	None	None	Well drained	Moderately Rapid	No
PlB	Platner loam	0–3%	None	None	Well drained	Rapid	No
PlC	Platner loam	3–5%	None	None	Well drained	Rapid	No
ReD	Renohill loam	3–9%	None	None	Well drained	Moderately Rapid	No
ShF	Samsil-Shingle complex	3–35%	None	None	Well drained	Moderately Slow	No
Tc	Terrace escarpments	N/A	None	None	Excessively drained	Very Rapid	No
UlC	Ulm loam	3–5%	None	None	Well drained	Rapid	Yes; 2%
UlD	Ulm loam	5–9%	None	None	Well drained	Rapid	Yes; 2%
W	Water	N/A	None	None	N/A	N/A	Yes; 10%
Wt	Wet alluvial land	N/A	Frequent	None	Poorly drained	Very Rapid	Yes;100%

Source: NRCS (2020)

3.11.8.1.2 Geologic Characteristics

According to the Adams County Colorado Geologic Features map (2005), surface geology in areas crossed by the Project consists predominantly of sedimentary rock such as mudstone, sandstone, claystone, and conglomerates of the Denver and Arapahoe Formations, modern alluviums, eolian deposits, and gravel and alluviums. A geotechnical study would be performed at select locations along the pipeline route as needed prior to the initiation of construction activities.

3.11.8.1.3 Natural Hazards

The Project passes through multiple 100-year floodplains within Adams County (Exhibit B, Figure 3). Sensitive aquatics features as discussed in Sections 3.11.3 and 3.11.5 would be identified through field reconnaissance and avoided. In the Denver Basin, most aquifer recharge occurs in the highland areas between stream channels in the topographically higher southern part of the basin (El Paso, Elbert, Douglas counties). Precipitation is greater in this area, and the permeable soils derived from the Dawson Arkose formation enable deep percolation (USGS 2009). Recharge to this area of the South Platte River basin primarily occurs as infiltration of precipitation, infiltration of ephemeral stream water, deep percolation of water applied to irrigated, agricultural fields and seepage beneath irrigation ditches (Arnold 2010). The Project is located within the northern portion of the Denver and Arapahoe aquifers and consist of shallow and temporary soil disturbance. Impacts to aquifer recharge are not anticipated.

Steep terrain is typically avoided or excluded during routing because constructing a pipeline and access roads on steep slopes could require complex engineering and erosion controls around the pipeline and

may result in greater potential environmental impacts. The pipeline is not expected to be installed in areas with slopes greater than 8 percent; however; if steep terrain is encountered, the pipeline may be installed using HDD and no additional measures would be needed for this sloped area. Pioneer would avoid other areas of steep slopes. No geotechnical hazards such as faults and fissures, unstable slopes, expansive or evaporative soils, or risk of subsidence of upheaval have been identified that might affect the ability to safely construct or operate the Project. The Project is located in a rural agricultural area that is not generally subject to wildfire hazard.

3.11.8.2 Risks to the Project from Natural Hazards

Based on the location of the Project in the Colorado Front Range and general agricultural setting, the Project would not be subject to significant risk from natural hazards.

3.11.8.3 Impact and Net Effect of the Project on Soil and Geologic Conditions in the area

Pipeline construction is not anticipated to impact long-term soil productivity. The pipeline would be primarily installed underground in a shallow (approximately 4 feet deep) trench and would not affect soil and geologic conditions in the area, impact any streambed meander limits, or affect aquifer recharge. The staging areas in Adams County are described in Section 3.3.3. These staging areas are limited in extent and will be sited to limit affect soil and geologic conditions, streambed meander limits or aquifer recharge areas.

3.11.9 Nuisances

Short-term localized impacts are anticipated from a temporary increase in traffic, construction equipment exhaust (fumes), and clearing and preparing areas for construction. The short-term impacts are not expected to result in nuisance effects. If a nuisance arises during construction, the nuisance would be mitigated in coordination with Adams County. The following sections address potential nuisances that may arise, as a result of the Project.

3.11.9.1 Noise

Project construction is expected to take place between the hours of 7 AM and 7 PM, is not expected to exceed 80 decibels on the A-weighted scale (dBA) and would therefore be in conformance with Section 4-13-03.2 of the ACDSR.

Major activities involved in construction of the Project would include staging materials, produced water pipeline trenching and boring, produced water pipeline fusing and installation, pressure-testing, backfilling the pipeline trench, installation of valve sets, re-contouring and revegetation. See Section 3.3.3 for a description of these activities. Construction at night is not anticipated but may occur in coordination and with approval from Adams County.

The construction phase would produce noise because heavy equipment would be required to build the proposed produced water pipeline and valve sets. Sound levels would fluctuate, depending on the construction activity, equipment type and distance between noise source and receiver. Sound from construction equipment would vary dependent on the construction phase and the number and type of

equipment a location at any given time. The variation in power and usage imposes additional complexity in characterizing construction noise levels

The following mitigation measures would reduce the potential for temporary adverse noise impacts during construction:

- Advertise a Project hotline and email whereby residents can contact Pioneer directly with their noise concerns. Throughout construction and operation of the Project, Pioneer would document, investigate, and attempt to resolve legitimate Project-related noise complaints.
- Notify landowners who may be directly impacted along the ROW prior to noisy construction activities.
- Coordinate construction vehicle travel to reduce the number of passes by sensitive receptors.
- Restrict noisy construction activity, which causes off-site annoyance as evidenced by the filing of a legitimate noise complaint, would be restricted to daytime hours (i.e., 7 AM to 7 PM) unless construction during nighttime hours is requested by Pioneer.

The produced pipeline would be buried underground. No noise is expected to be generated by the produced water pipeline during operation. The valve sets would be unmanned facilities. No noise is expected to be generated at the valve sets during operation, except when crews are onsite to perform routine maintenance activities. Noise generated as a result of routine maintenance activities would be short term.

3.11.9.2 Glare

Glare is not anticipated to be generated by the Project because the produced water pipeline would be buried underground. The aboveground piping associated with aboveground appurtenances would not have a reflective surface.

3.11.9.3 Dust

Limited dust would be generated during all construction phases with the exception of pressure testing. Dust suppression measures that would be implemented during construction, BMPs, and site restoration and revegetation activities are discussed in Tables 12 and 13. Pioneer will submit a CDPHE APEN including a dust suppression plan prior to construction, and CDPHE would stipulate additional mitigation, monitoring and recordkeeping requirements for a minor source construction air permit if required.

3.11.9.4 Fumes

Fumes would be generated during construction from construction equipment exhaust. Fumes from vehicles would also be generated during operation of the Project and would include fumes from trucks used for routine maintenance activities along the pipeline or at valve set locations. Impacts during construction and operation as a result of fumes would be short term and localized to the location of construction equipment and delivery trucks. Additional air quality information is included in Section 3.11.1.

3.11.9.5 Vibrations

Minimal vibration would occur during construction due to the use of heavy machinery and operations such as drilling and trenching. The vibrations would be temporary in nature and limited to the immediate area

around the construction work. Any vibrations would last only during the construction timeframe and only be experienced within the 50-foot-wide construction zone adjacent to construction vehicles. No vibrations are expected during operation of the pipeline.

3.11.9.6 Odors

An odor is the property of a substance to stimulate chemical sense receptors that sample the air in and around human or animal (Encyclopedia Britannica 2012). Existing odors in the vicinity of the pipeline route may include diesel exhaust from vehicles, vehicles traveling on adjacent roadways, and agricultural operations immediately surrounding the Project.

Odors resulting from construction of the Project may include vehicle and equipment exhaust. These odor emissions are expected to be short term and transient in nature, limited to the area of active construction, and adequately dispersed by diurnal winds.

During commissioning, startup, and long-term operations and maintenance of the Project, odors would be minimal and limited to the use of on-site maintenance equipment.

3.11.10 Areas of Paleontological, Historic or Archaeological Importance

3.11.10.1 Description of All Sites of Paleontological, Historic, or Archaeological Interest

Tetra Tech completed a desktop analysis to identify cultural and historic resources listed on the National Register of Historic Places (NRHP), determined or recommended eligible for the NRHP, or that remain unevaluated for listing on the NRHP that may be impacted by construction of the Project. No potentially significant cultural resources are expected to be impacted by the Project. Pioneer would have an Unanticipated Discovery Plan in place for the Project, however. Please refer to Attachment 2 of the NRCO report for the full Cultural Resources Class I Letter Report and additional information regarding cultural resources.

3.11.10.2 Impacts and Net Effect of the Project All Sites of Paleontological, Historic, or Archaeological Interest

The results of a Class I cultural resources survey conducted in January 2020 did not identify any significant cultural, historic, or archaeological resources within the Project in Adams County that could not be avoided. Should any additional undiscovered paleontological, historic, or archaeological artifacts be uncovered during construction activities that are not previously identified, such activities would be temporarily stopped until a qualified person can evaluate the object of interest as outlined in the Unanticipated Discovery Plan.

3.11.11 Hazardous Materials Description

3.11.11.1 Hazardous, Toxic, and Explosive Substances To Be Used, Stored, Transported, Disturbed or Produced in Connection with the Project

Upon completion, the pipeline would transport produced water to the existing EWS #6 water facility located in Weld County. The Project includes the placement of remote isolation valves spaced throughout the Project within Adams County for the purpose of providing emergency safety isolation along the pipeline.

Toxic or explosive substances would not be stored in construction areas or along the pipeline or associated valve sets during operations. There are no chemical or waste storage facilities associated with the Project.

Hazardous chemicals that may be used during construction and operation are those found in diesel fuel, gasoline, coolant (ethylene glycol) and lubricants in machinery. Hazardous materials would not be drained onto the ground or into streams or drainage areas. Enclosed containment would be provided for waste disposal. Pioneer does not expect that the Project will generate hazardous materials during any phase of the Project, however construction waste, including trash and litter, garbage, other solid waste, petroleum products and other potentially hazardous materials would be removed to a disposal facility authorized to accept such materials. The hazardous materials identified above may be stored in trucks in small quantities overnight within unincorporated Adams County.

Pioneer and its contractors would provide and maintain sanitary accommodations for the use of their employees during construction of the Project in a manner that would comply with the requirements and regulations of health departments and of other governmental bodies. These accommodations, including trash dumpsters and portable waste facilities (toilets), would be located in several locations along the construction route based on the construction plan. The final numbers, locations, and vendors would be provided by the construction contractor. Construction waste would be stockpiled in the construction staging areas and would be removed from the construction sites during the construction process.

3.11.11.2 Location of Storage Areas

Temporary workspaces are discussed in Section 2.3. These areas would be used to temporarily store pipeline construction materials as well as necessary construction equipment. Spill containment measures would be specified in the site-specific SWMP. Temporary workspaces are discussed in Section 2.3.4 and would also be used to temporarily store pipe and other materials necessary for construction HDD activities.

3.11.11.3 Reportable Quantities, Emergency Response Plan

Reference Section 2.3.5 for information regarding Project safety.

In addition, the Project would be designed and operated per the Pioneer internal operating standards and practices and written maintenance procedures including the development of a site-specific Emergency Response Plan.

Construction activities would be performed by methods that prevent discharge or accidental spillage of solid matter, contaminants, debris, and other pollutants and wastes into flowing streams or dry watercourses, lakes and underground water sources. During construction, the focus would be primarily on containment-type BMPs.

Temporary workspaces would be located and arranged in a manner to preserve trees and vegetation. Excavated material or other construction materials would not be stockpiled or deposited near or on-stream banks or other watercourse perimeters where they could be washed away by high water or storm runoff or could encroach upon stream banks.

Fueling vehicles would be equipped with spill kits and fire extinguishers and personnel would be properly trained in spill prevention control and countermeasures. Based on review of available information from federal and state databases, construction activities associated with the Project are not anticipated to encounter known areas of soil or groundwater contamination. In general, if trenching or HDD activity uncovers previously unknown areas of contamination, work would immediately be stopped until a pre-determined Pioneer contact is notified and consulted. Pioneer or its contractor would then perform all necessary testing and handling of such materials as required by applicable state and/or federal requirements.

3.11.11.3.1 Emergency Response

Pioneer would prepare a site-specific Emergency Response Plan to establish emergency protocols for the produced water pipelines and associated facilities. The purpose of this plan is primarily to minimize the hazard to the public, Pioneer's employees and to property and secondarily to reestablish service should a service interruption occur. The plan would establish procedures and defines responsibilities prior to, during, and following an emergency and includes contact information and instructions for all such anticipated emergency situations. The plan would describe the specific responsibilities of Pioneer responders including dispatchers and emergency responders.

3.11.11.3.2 Routine Maintenance

Routine maintenance of the Project facilities would be performed as outlined in Pioneer's internal operating standards and practices and written maintenance procedures, which meet or exceed regulatory requirements. Maintenance activities associated with the Project would include, but are not limited to:

- Implement a damage prevention program, including observation of any construction activities by others on or near the permanent easement.
- Participate in the State of Colorado's one-call program and responding to one-calls.
- Implement a public education program.
- Install and maintain pipeline markers.
- Inspect block valves.
- Inspect crossings by other pipelines, highways, railroads and utilities.
- Inspect and maintain safety, control, mechanical and electrical equipment.
- Maintain communication equipment.
- Calibration of all instruments.

3.11.12 Balance Between Benefits and Losses

3.11.12.1 Foreseeable Benefits of Natural, Agricultural, Recreational, Range, or Industrial Resources

There would be no anticipated loss of resources within Adams County or loss of opportunities to develop such resources. Industrial resources and future opportunities to develop commercial and industrial resources would be supported by the Project because it would continue to support the oil and gas industry and help support future growth.

3.11.12.2 Foreseeable Losses of Natural, Agricultural, Recreational, Range, or Industrial Resources

The majority of the project ROW in Adams County is located within agricultural/rangeland. Pioneer's restoration contractor would restore the pipeline ROWs to pre-construction conditions. Native shortgrass prairie is not present at a measurable quantity within the pipeline ROW. Potential impacts to wetland

would be minimal based on desktop analysis. Impacts to wetlands are not anticipated to extend past one to two growing seasons (see Section 3.11.5). The Project would not adversely affect future opportunities to develop commercial and industrial resources. The pipeline ROW has been routed with landowner considerations to maximize the use of existing ROWs and property boundaries and to avoid potential conflict with land use and development.

3.11.13 Monitoring and Mitigation

3.11.13.1 Description of All Mitigation for the Project

Mitigation and monitoring activities have been described as related to environmental and community resources and concerns throughout this document. Construction and operation mitigation activities would be financed as a part of the cost of the Project. BMPs listed in Tables 12 and 13 are intended to minimize disturbed area and to protect natural features. Mitigation would be completed during and after construction until the ROW has been restored.

3.11.13.2 Methodology Used to Measure Impacts

Field investigations would be conducted in spring 2020 to define potential aquatic and terrestrial resources, wildlife, and cultural resources baseline and impacts more accurately. As needed, additional mitigation and/or studies would be proposed following the pedestrian surveys and analysis specific to the resources identified and potential impacts.

Fugitive dust emissions during construction would be controlled with the implementation of BMPs including application of water during high wind conditions to eliminate fugitive dusts. The SWMP would specify BMPs to be followed during construction activities that would minimize erosion and impacts to water quality from storm events. The implementation of dust controls and stormwater BMPs include monitoring requirements.

3.11.13.3 Description of Location and Intervals of Proposed Monitoring

Construction monitoring may be required for stormwater, erosion control, air quality, wildlife, cultural and historic resources, and other resources. During construction of the Project, BMPs would be monitored either by Pioneer or by Pioneer's contractor to ensure their effective implementation. For example, the effectiveness of dust suppression and stormwater management controls would be evaluated. An environmental inspector would also monitor sediment erosion control facilities during construction to ensure compliance with the SWMP.

Post-construction monitoring would be completed for stormwater/erosion, ROW restoration, and weed control until all permit requirements have been met and all landowners' requirements have been met. The Project intersects approximately 2.8 miles of area designated within the Adams County Stormwater Permit Area. Therefore, Pioneer will likely be required to obtain an Adams County Stormwater Quality (SWQ) Permit for Construction.

3.12 60-07-02-12. Referrals to Outside Agencies, Response to Referral Comments and Neighborhood Scoping Meeting

To date, no referrals or responses from outside agencies has been received to date. A description of the Neighborhood Meeting is included in Section 2.13.1.

4. Section 2-02-08-06. CUP Approval Criteria

The Planning Commission, in making their recommendation, and the Board of County Commissioners, in approving a conditional use permit, shall find:

1. *The conditional use is permitted in the applicable zone district.*

   Response in this Application. In consultation with the Adams County Department of Community Planning and Development, Pioneer has been advised that the produced water pipeline is subject to the County CUP review and approval in zone districts crossed by the Project. Reference Section 3.6 for additional information regarding the existing land use plans and potential Project impacts.

   Reference Sections. Section 2.3—Written Explanation of the Project, Section 3.6—Land Use.

2. *The conditional use is consistent with the purposes of these standards and regulations.*

   Response in this Application. The Project would remain consistent with the purposes of the ACDSR's goals to "control and assist in the orderly, efficient, and integrated development of the County, in order to preserve the health, safety, and welfare of the public, in accordance with established County policies and plans" (ACDSR 1-01-03). All required permits would be obtained from the appropriate federal, state, or local agency prior to construction. Table 7 in Section 3.4.2 describes the permits and approvals required by the Project and their status.

   Reference Sections. Section 3.4—Property Rights, Permits and Other Approvals

3. *The conditional use will comply with the requirements of these standards and regulations including, but not limited to, all applicable performance standards.*

   Response in this Application. The Project would remain consistent with ACDSR's performance standards outlined in Chapter 4—Design Requirements and Performance Standards. All other federal, state, and local standards would be upheld including the COGCC Series 1100 Rules, Colorado Department of Transportation Construction Standards, Clean Water Act Sections 404 and 401, etc.

   Reference Sections. Section 2.3—Written Explanation of the Project and Section 3.4—Property Rights, Permits and Other Approvals.

4. *The conditional use is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County. In making this determination, the Planning Commission and the Board of County Commissioners shall find, at a minimum, that the conditional use will not result in excessive traffic generation, noise, vibration, dust, glare, heat, smoke, fumes, gas, odors, or inappropriate hours of operation.*

   Response in this Application. The Project is compatible with the surrounding area and its operation would not result in permanent additional nuisances to the local population. Overall, the produced

water pipeline is not expected to affect visual quality. The produced water pipeline would be installed by means of trenching or by HDD, and it ultimately would be buried underground and so would be compatible with the surrounding area and harmonious with the character of surrounding rural and agricultural land uses. Aboveground appurtenances would be similar to other ancillary facilities associated with oil and gas in the area and therefore would not be out of character in the landscape.

Short-term localized noise impacts are anticipated from a temporary increase in traffic, construction equipment exhaust (fumes), and clearing and preparing areas for construction. The short-term impacts are not expected to result in nuisance effects. If a nuisance arises during construction, the nuisance would be mitigated in coordination with Adams County. Section 3.11.9 address potential nuisances that may arise as a result of the Project.

Reference Sections. Section 3.11.2—Visual Quality and Section 3.11.9—Nuisances

5. *The conditional use permit has addressed all off-site impacts.*

Response in this Application. Pioneer is committed to safety and would follow all federal, state, and local rules and regulations to provide safe, reliable service for Pioneer's customers. Off-site impacts due to construction or operation of the pipeline were considered during the planning, siting, and routing process of the pipelines (Sections 3.3.2). The pipeline routes would be located underground and their operation would not produce any nuisances or inconveniences to nearby landowners or the general public.

Construction of the Project would incorporate mitigation measures that would minimize impacts to water quality, water use, existing land uses, local government resources, cultural resources, and the natural environment. Pioneer would use a SWMP for implementation of BMPs to mitigate soil erosion, control noxious weeds, and revegetate disturbed areas. Groundwater quality also would be protected through the implementation of a SWMP and through the implementation of waste management BMPs during construction.

Given the location of the route along existing roadways and agricultural areas, noise during construction has been partially mitigated by avoiding dense population areas, and following unpopulated and rural populated areas. The resulting noise would not be uncharacteristic of typical noise from day-to-day activities in the area. Dust suppression would be conducted during construction and would not be uncharacteristic of the dust created by existing agricultural activities. No other off-site impacts to air or water quality are expected as a result of construction or operation of the facilities or pipelines. During construction, an increase in traffic is expected to be negligible.

Reference Sections. Exhibit H—Routing Analysis, Section 3.3.1—Detailed Plans and Specifications of the Project, Section 3.11.1—Air Quality, Section 3.11.2—Visual Quality, Section 3.11.4—Groundwater Quality and Quantity, and Section 3.11.9—Nuisances

6. *The site is suitable for the conditional use including adequate usable space, adequate access, and absence of environmental constraints.*

   Response in this Application. Pioneer conducted a thorough review of the pipeline route. Pioneer is seeking a permanent easement for its pipelines that is approximately 10 feet wide, along with an additional 30 feet of temporary easement, for a total construction corridor of 40 feet in width. Appurtenant aboveground appurtenances such as isolation valves, pumps, and cleaning tool launcher and receivers would be located at the existing oil and gas production facilities. Within unincorporated Adams County, approximately five aboveground appurtenances (reference Section 2.3.4) would be located along the pipelines within the 10-foot-wide pipeline easements.

   Pioneer does not anticipate using additional temporary workspaces in unincorporated Adams County besides the temporary workspaces located along the pipeline route, which would be used to excavate trench, fuse pipeline segments, deliver the HDD equipment and pipe segments, excavate HDD entry and receiving pits, temporarily stockpile excavated soil from the pits, and serve as laydown for pipe segments. Following construction, the contractor would return temporary workspaces to pre-construction conditions.

   The pipeline would be constructed on private land with the exception of CDOT ROW crossings and one Adams County-owned parcel (parcel #157123401001). The pipeline would be installed using HDD and would not impact the existing South Platte River Trail on this parcel. The pipeline would be located underground for its entire length and Pioneer would minimize impacts to sensitive water resources and public roads using HDD techniques where possible. The pipeline easements could continue to be farmed after the pipeline is installed.

   Section 3.7.3 describes haul routes that would be used during construction of the Project. None of these roads are expected to experience a significant impact from the delivery of materials during construction. It is not expected that Pioneer's construction contractor would need to improve or close any roads, intersections, or bridges to accommodate oversized truck deliveries to the Project.

   Reference Sections. Section 2.3—Written Explanation of the Project, Section 3.7.3—Potential Effect of the Project on the Existing Transportation Network.

7. *The site plan for the proposed conditional use will provide the most convenient and functional use of the lot including the parking scheme, traffic circulation, open space, fencing, screening, landscaping, signage, and lighting.*

   Response in this Application. The pipeline would not interfere with the agriculture use in the area and is generally routed near and parallel to section lines, property lines, and existing utility corridors to minimize impacts on future development. The aboveground appurtenances are not visually sensitive given the existing oil and gas infrastructure in the area and they would appear as a minor feature in the landscape. It is anticipated that the Project would not adversely impact area visual resources.

   Reference Sections. Section 2.3—Written Explanation of the Project, Section 3.11.2—Visual Quality and Section 3.11.9—Nuisances.

8. *Sewer, water, storm water drainage, fire protection, police protection, and roads are to be available and adequate to serve the needs of the conditional use as designed and proposed.*

   Response in this Application. Pioneer accounted for all sewer, water, stormwater drainage, fire protection, police protection, and road availability to serve the needs of the Project. The pipelines would be located underground and would not require utility services (i.e., sewer, water, stormwater drainage, etc.), or the construction of new roads.

   As discussed in Section 3.11.11, Pioneer would follow an Emergency Response Plan, which would include procedures and directions for emergency dispatch in the case of a pipeline emergency. The Project would not increase fire protection demands. Appurtenant aboveground facilities such as isolation valves, pumps, and cleaning tool launcher and receivers would be located at the existing oil and gas production facilities. Aboveground appurtenances within unincorporated Adams County would be located on private land and outside of storm water drainage facilities and floodplains. The Project does not anticipate an increase in police protection.

   It is not expected that Pioneer's construction contractor would need to improve or close any roads, intersections, or bridges to accommodate oversized truck deliveries to the Project. See Section 3.7.3 for additional information about the Project and its effect on local transportation networks.

   Reference Sections. Section 2.3—Written Explanation of the Project, Section 2.7—Proof of Water and Sewer Services, and Section 3.7—Local Government Services.

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Figures

PIONEER PRODUCED WATER PIPELINE PROJECT

Figure 1: Project Overview Map

EWS #6
Pioneer Mainline
S Weld Trunk
Pioneer Mainline
Ritchey Lateral
RICTHEY PAD
SACK PAD
DITTMER PAD
RAEL PAD
Dittmer Lateral
Otteson Lateral
OTTESEN PAD
Seltzer Lateral
MARCUS PAD
N Adams Trunk
RIO PAD
Rio Lateral
Pioneer Mainline
SELTZER PAD
BASELINE PAD
B-FARM PAD
Ocho Connection
TOLLWAY PAD
B-Farm Connection
OCHO PAD
BRANT PAD
Tollway Connection
IVEY PAD
Ivey Lateral
Kortum Lateral
S Adams Trunk
Tower Lateral
TOWER PAD
Gus Lateral
KORTUM PAD
GUS PAD
HENDERSON PAD
Henderson Lateral
SHARP PAD
SCHAEFER PAD
PRAIRIE PAD
RICO PAD
S Adams Trunk
BELLA ROSA PKWY
CR 20
CO RD 20
GODDING HOLLOW PKWY
TIPPLE PKWY
CO RD 16
CO RD 14 1/2
14TH ST
9TH ST
CO RD 14
GRANDVIEW BLVD
CO RD 12
SUMMIT BLVD CO RD 8
CO RD 10
CO RD 6
CO RD 4
CO RD 2
E 168TH AVE
BASELINE RD
E 160TH AVE
E 156TH AVE
E 136TH AVE
E 144TH AVE
E BROMLEY LN
S 27TH AVE
WELD COUNTY
ADAMS COUNTY
BROOMFIELD COUNTY
South Platte River
Little Dry Creek
Big Dry Creek
Todd Creek
Second Creek
Denver-Hudson Canal
WELD COUNTY CR 11
COLORADO BLVD CO RD 13
CO RD 15
CO RD 17
CO RD 19
CO RD 21
CO RD 23
CO RD 27
CO RD 29
RD 11
RD 15
RD 4
YORK ST
HOLLY ST
QUEBEC ST
YOSEMITE ST
TUCSON ST
N MAIN ST
S MAIN ST
RIVERDALE RD
BRIGHTON RD
SABLE BLVD
BUCKLEY RD
CO RD 31
CO RD 18
US 85
I 76
I 25
I 70
I 270
SH 52
SH 7
SH 2
SH 22

Legend

- EWS #6
- Pioneer Produced Water Pipeline
- Oil and Gas Production Facility

Transportation
- Interstate
- U.S. Highway
- Major Local Road
- Railroad

Jurisdiction
- Brighton
- Broomfield
- Commerce City
- Dacono
- Firestone
- Fort Lupton
- Frederick
- Northglenn
- Thornton
- County Boundary

0 1 2 Miles

Scale is 1:37,500 when printed at 22x34

NOT FOR CONSTRUCTION

Sources: CDOT 2015, US Census 2019, BTS 2019, NHD 2019

The route shown in this figure is a graphical representation and may not show exact locations. The pipeline alignment is subject to change based on final engineering.

TETRA TECH

LARIMER COUNTY
WELD COUNTY
MORGAN COUNTY
BOULDER COUNTY
BROOMFIELD COUNTY
GILPIN COUNTY
ADAMS COUNTY
CLEAR CREEK COUNTY
JEFFERSON COUNTY
ARAPAHOE COUNTY
PARK COUNTY
ELBERT COUNTY

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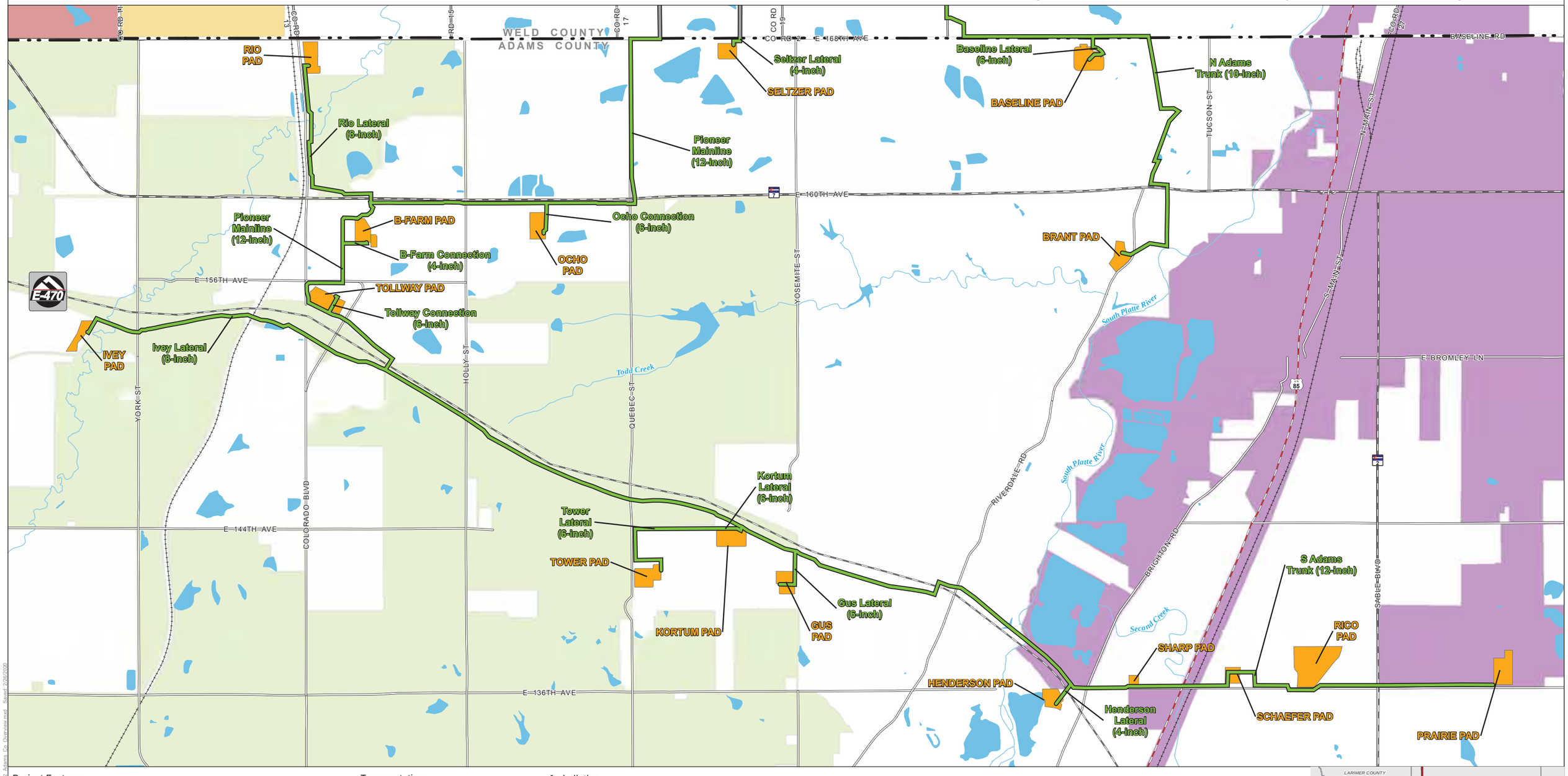
Adams and Weld Counties, CO

PIONEER PRODUCED WATER PIPELINE PROJECT

Figure 2: Adams County Overview Map



Project Features
- Pioneer Produced Water Pipeline (Adams County)
- Pioneer Produced Water Pipeline (Weld County)
- Oil and Gas Production Facility

Transportation
- Interstate
- U.S. Highway
- Major Local Road
- Railroad

Jurisdiction
- Brighton
- Broomfield
- Northglenn
- Thornton
- County Boundary

The route shown in this figure is a graphical representation and may not show exact locations. The pipeline alignment is subject to change based on final engineering.

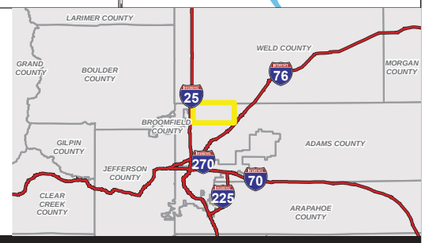
Sources: CDOT 2015, US Census 2019, BTS 2019, NHD 2019

0 0.5 1 Miles

Scale is 1:18,000 when printed at 22x34

NOT FOR CONSTRUCTION

TETRA TECH



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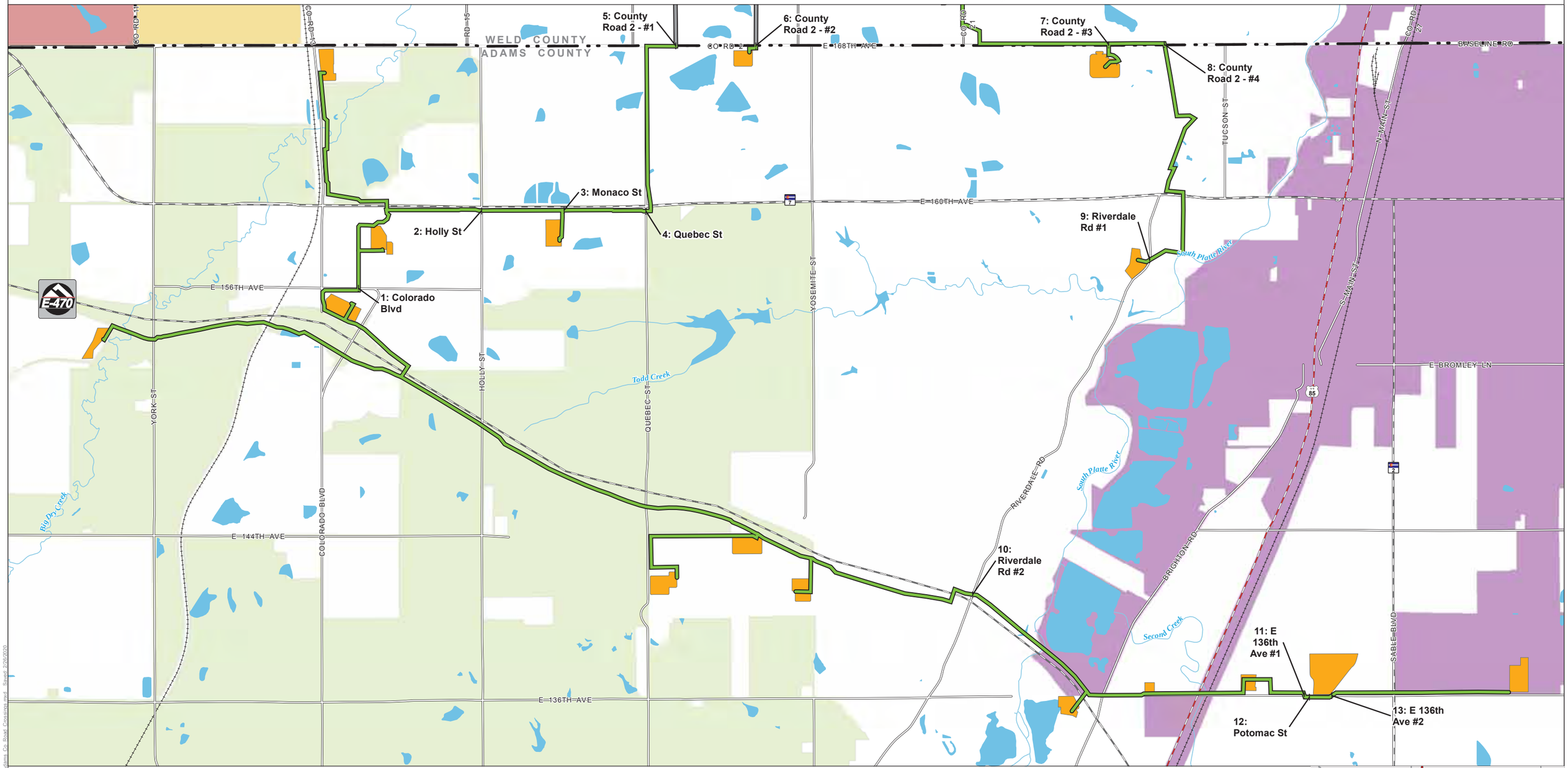
PIONEER PRODUCED WATER PIPELINE PROJECT

Figure 3: Adams County Road Crossings Map



Project Features

- ! Road Crossing
- Pioneer Produced Water Pipeline (Adams County)
- Pioneer Produced Water Pipeline (Weld County)
- Oil and Gas Production Facility

Transportation

- Interstate
- U.S. Highway
- Major Local Road
- Railroad

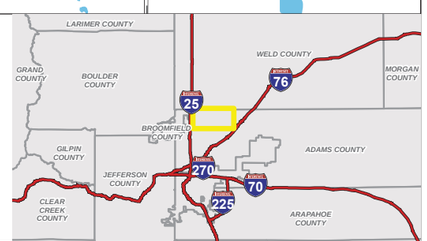
Jurisdiction

- Brighton
- Broomfield
- Northglenn
- Thornton
- County Boundary

0 0.5 1 Miles

Scale is 1:18,000 when printed at 22x34

NOT FOR CONSTRUCTION



Sources: CDOT 2015, US Census 2019, BTS 2019, NHD 2019

The route shown in this figure is a graphical representation and may not show exact locations. The pipeline alignment is subject to change based on final engineering.

TETRA TECH

Adams County, CO

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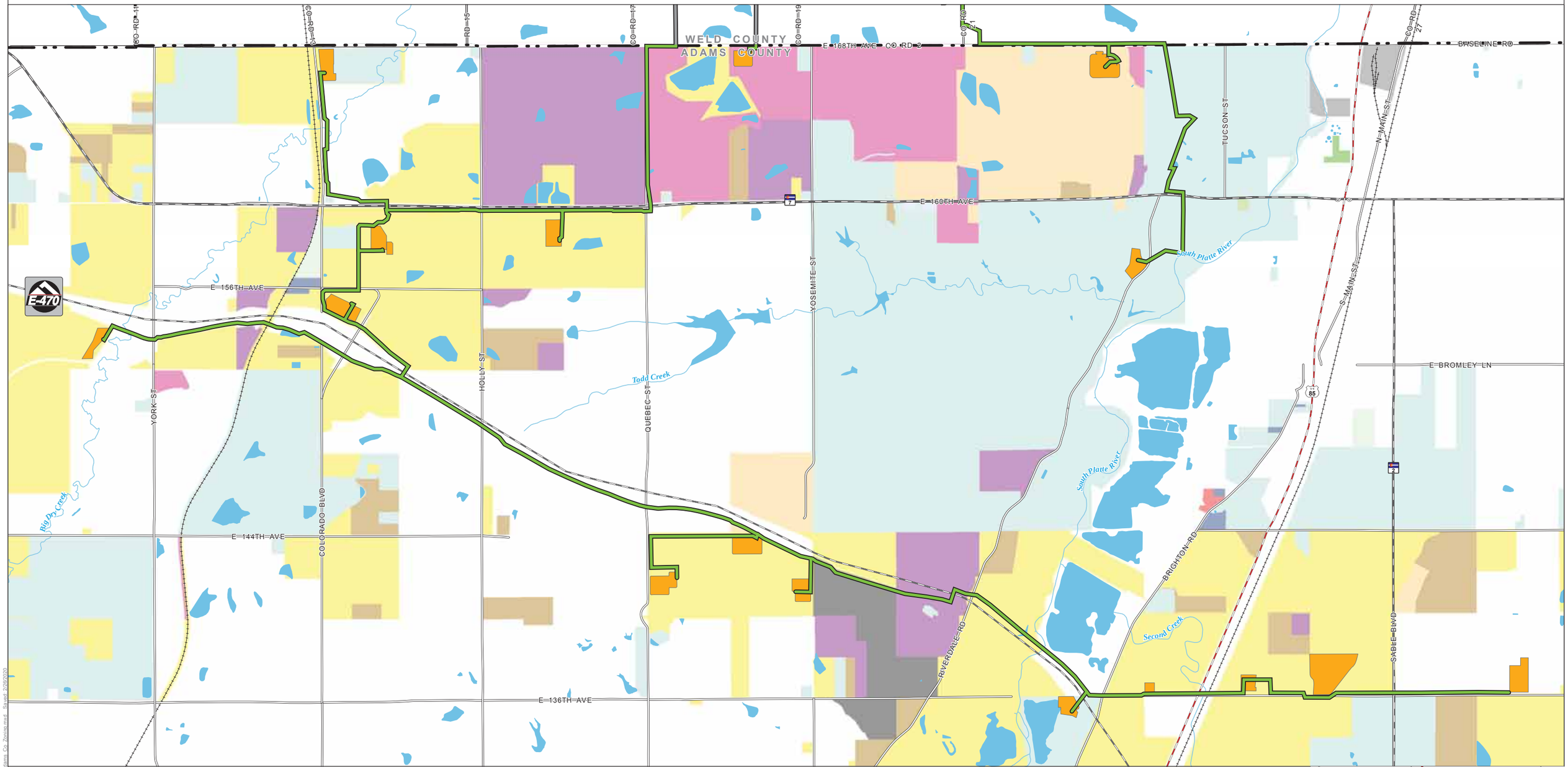
PIONEER PRODUCED WATER PIPELINE PROJECT

Figure 4: Adams County Zoning Map



Project Features
- Pioneer Produced Water Pipeline (Adams County)
- Pioneer Produced Water Pipeline (Weld County)
- Oil and Gas Production Facility

Transportation
- Interstate
- U.S. Highway
- Major Local Road
- Railroad

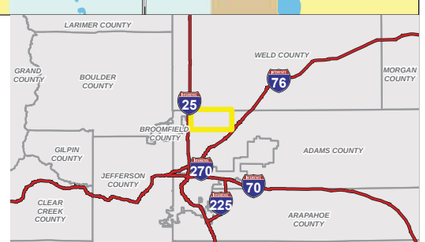
Zoning

A-1	C-5	R-1-C
A-2	I-1	R-E
A-3	I-2	
C-2	I-3	
C-3	P-U-D	
C-4	P-U-D(P)	
	PL	

0 0.5 1 Miles

Scale is 1:18,000 when printed at 22x34

NOT FOR CONSTRUCTION



The route shown in this figure is a graphical representation and may not sh ow exact locations.
The pipeline alignment is subject to change based on final engineering.

Sources: CDOT 2015, US Census 2019, BTS 2019, NHD 2019, Adams County 2020

TETRA TECH

Adams County, CO

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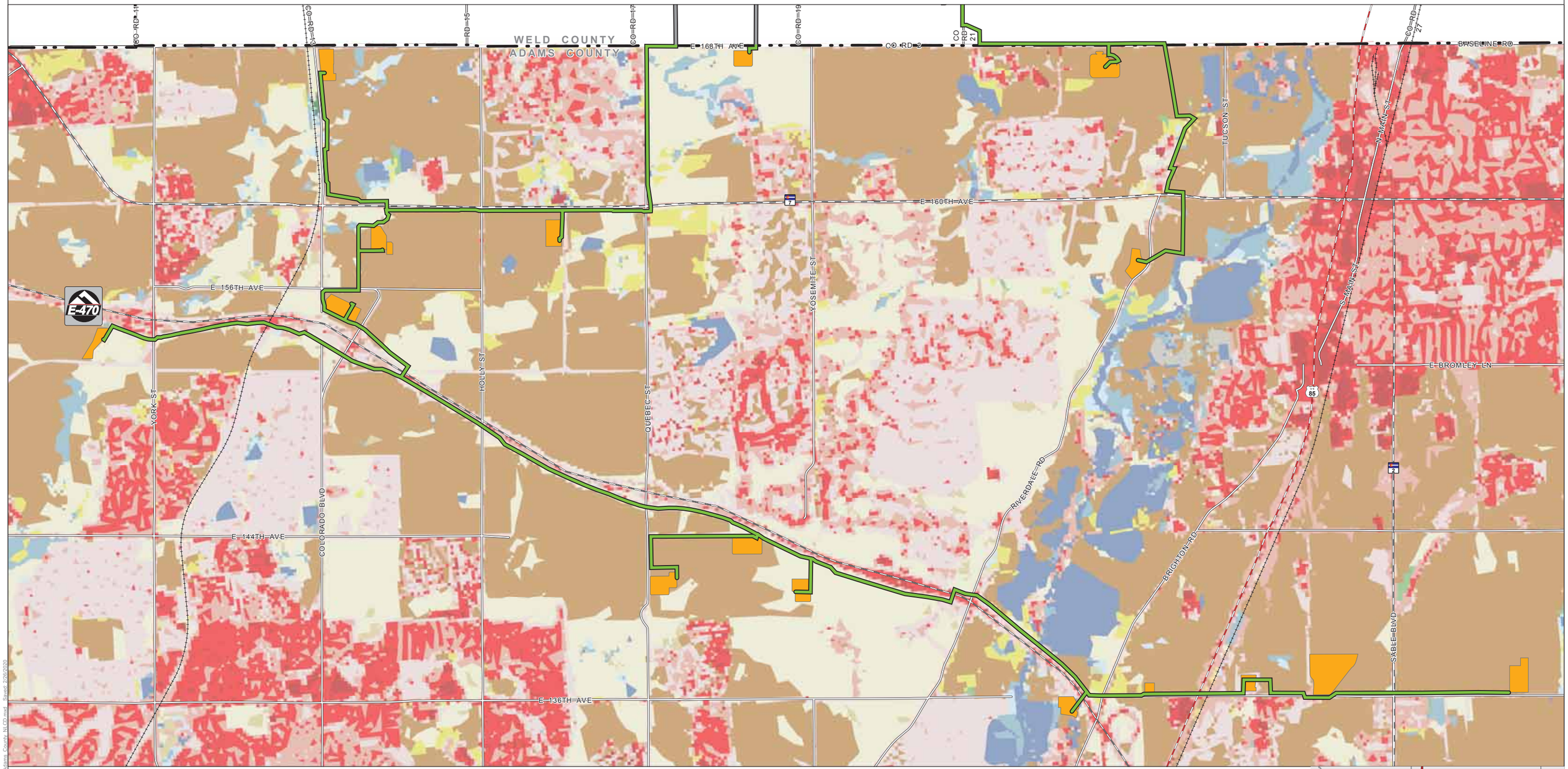
PIONEER PRODUCED WATER PIPELINE PROJECT

Figure 5: Adams County Land Cover Map



Project Features
- Pioneer Produced Water Pipeline (Adams County)
- Pioneer Produced Water Pipeline (Weld County)
- Oil and Gas Production Facility

Jurisdiction
- County Boundary

Transportation
- Interstate
- U.S. Highway
- Major Local Road
- Railroad

Land Cover
- Open Water
- Developed, Open Space
- Developed, Low Intensity
- Developed, Medium Intensity
- Developed, High Intensity
- Barren Land (Rock/Sand/Clay)
- Deciduous Forest
- Evergreen Forest
- Mixed Forest
- Shrub/Scrub
- Grassland/Herbaceous
- Pasture/Hay
- Cultivated Crops
- Emergent Herbaceous Wetlands
- Woody Wetlands

Sources: CDOT 2015, US Census 2019, BTS 2019, NLCD 2016

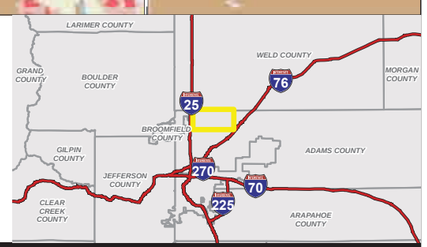
0 0.5 1 Miles

Scale is 1:18,000 when printed at 22x34

NOT FOR CONSTRUCTION

The route shown in this figure is a graphical representation and may not show exact locations. The pipeline alignment is subject to change based on final engineering.

TETRA TECH



Adams County, CO

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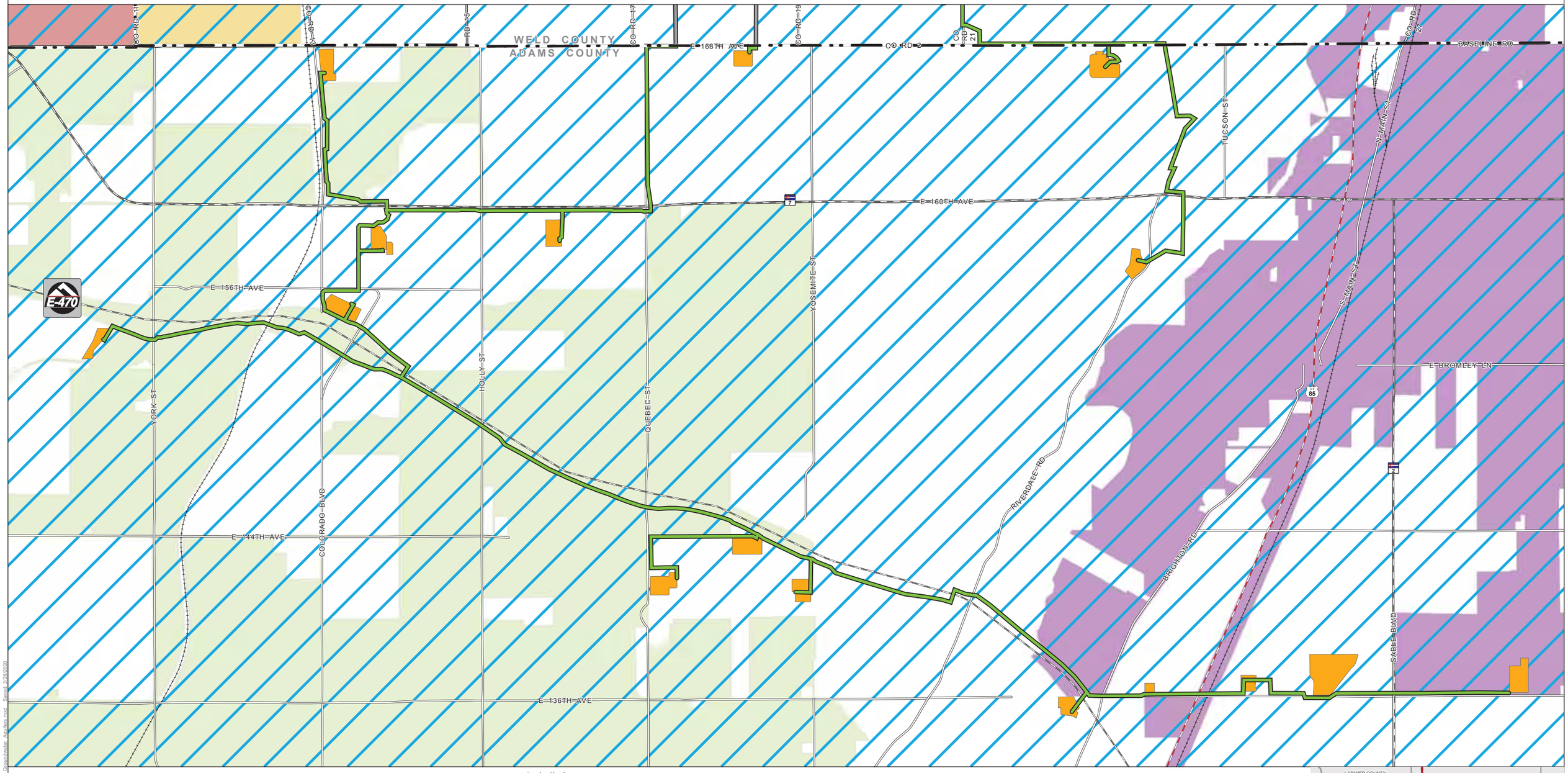
PIONEER PRODUCED WATER PIPELINE PROJECT

Figure 6: Adams County Groundwater Aquifers Map



Project Features
- Pioneer Produced Water Pipeline (Adams County)
- Pioneer Produced Water Pipeline (Weld County)
- Oil and Gas Production Facility

Transportation
- Interstate
- U.S. Highway
- Major Local Road
- Railroad

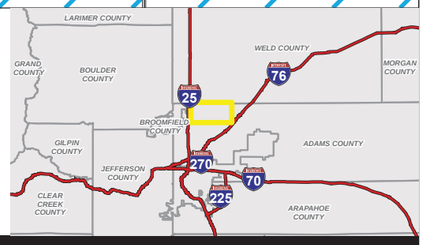
Jurisdiction
- Brighton
- Broomfield
- Northglenn
- Thornton
- County Boundary

Groundwater Aquifer
- Denver Basin

0 0.5 1 Miles

Scale is 1:18,000 when printed at 22x34

NOT FOR CONSTRUCTION



The route shown in this figure is a graphical representation and may not sh ow exact locations. The pipeline alignment is subject to change based on final engineering.

Sources: CDOT 2015, US Census 2019, BTS 2019, USGS 2016

TETRA TECH

Adams County, CO

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Exhibit H:
Routing Analysis

Contents

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Tables

Figures

1. Introduction

Tetra Tech, Inc (Tetra Tech), has prepared this routing analysis on behalf of Pioneer Water Pipeline, LLC (Pioneer), a subsidiary of Expedition Water Solutions Colorado, LLC (Expedition), for the proposed Pioneer Water Pipeline Project (Project). The analysis was performed as required by Section 6-07-02-03 under Chapter 6 Regulations Governing AASI and the AASI Checklist for supplemental environmental impact analysis and as requested by Adams County during the Conceptual Review process.

1.1. Alternative Concepts Considered

The purpose of the Project is to allow more efficient pipeline transportation of produced water from oil and gas production facilities (OGPFs) in Adams and Weld counties to Expedition's existing EWS #6 wastewater injection and disposal facility, thereby also significantly reducing truck traffic. Without the Project, oil and gas producers will transport produced water from permitted OGPFs to EWS #6 by truck. Transport of produced water by truck was eliminated as an alternative because Pioneer expects construction of the Project will remove the equivalent of five million truck miles and over 50,000 truckloads per year on local roads.

2. Identification of Preferred Routes

Pioneer considered and eliminated several alternative routes prior to deciding the preferred route (Figure H-1). The routing process began by identifying the pipeline beginning points (permitted OGPFs, Figure 1) and the terminus (EWS #6, Figure 1). Alternative routes were then selected to minimize potential impacts. The total length of each pipeline within unincorporated Adams County, Weld County, and municipalities is listed in Table (Page8). The features of the alternative routes included:

- Meets the Project's purpose and need in transporting produced water to the existing EWS #6 facility from OGPFs operated by Great Western Petroleum in the shortest distance possible to reduce impacts and construction costs.
- Parallels existing roadways, pipeline/utility corridors, and section lines to the extent practicable to minimize the creation of new linear corridors.
- Is located within properties owned by landowners who are willing to grant an easement for the pipeline on their property.
- Minimizes potential disturbance to environmentally sensitive areas such as floodplains, wetlands, and federal/state species habitats.
- Minimizes impacts to major water crossings and topography constraints.
- Reflects Pioneer's consideration of compatible zoning and land uses.

The major considerations for the preferred route within Adams County was to parallel existing rights-of-way and circumventing to the extent possible existing and planned residential areas and intentionally not bisect them. Emphasis was also placed on working with landowners to identify what would be least impactful and securing easements for the Pioneer Water Pipeline on private land and public rights-of-way.

Consideration was also given to reducing the number and length of laterals needed to reach well pads by having the pipeline route run through the well pad sites as well as the shortest linear length of pipeline.

3. Route Descriptions and Comparative Analysis

The Project was divided into four zones for ease of identification of alternative routes (Figure 1). Descriptions of the preferred and alternative routes for each zone are described below:

3.1. Zone A

3.1.1. Preferred Route

This route originates on the eastern side of Zone A at the Brant LD OGPF. The pipeline travels east from the OGPF for 1,500 feet, crossing Riverdale Road and Brighton Ditch. The pipeline then turns north, crossing 160th Avenue and turning west, paralleling the north side of 160th Avenue, then turning north just before Brighton Ditch. The pipeline parallels the east side of Brighton Ditch for approximately 2,700 feet, where it turns west and crosses Brighton Ditch at a 90-degree angle. The pipeline turns north, crossing 168th Avenue and passing into Weld County. The pipeline parallels the north side of 168th Avenue as it travels west, crossing Brantner Ditch. Just west of Brantner Ditch, a lateral come from the Baseline LE OGPF on the south side of 168th Avenue, crossing the roadway to join the pipeline on the north side. The pipeline continues west along 168th Avenue, and as the pipeline reaches Havana Street turns, it north for 400 feet, then turns west, crossing County Road (CR) 21. The pipeline travels north, paralleling the west side of CR 21. A lateral connects the Marcus LD OGPF to the pipeline, located in Weld County. North of 168th Avenue, approximately 0.5 mile (2,600 feet), the pipeline turns west, crossing CR 19. Just west of CR 19, a lateral connecting the Seltzer LD OGPF to the pipeline, which crosses 168th Avenue from Adams to Weld county. The pipeline joins with the pipeline from Zone B and continues north into Weld County toward the EWS #6 facility. This route has secured easements, has the least amount of pipeline within Adams County, the least amount of waterway crossings, and is the furthest from the Todd Creek residential area.

- Route Length: 3.8 miles
- Route Length within unincorporated Adams County: 2.13 miles
- Route Length within unincorporated Weld County: 1.67 miles

3.1.2. Route A-1

This route originates on the eastern side of Zone A at the Brant LD OGPF. The pipeline travels north paralleling the east side of Brantner Ditch, then crossing Brantner Ditch near the location of the Brantner Ditch crossing of 160th Avenue. The pipeline continues north, paralleling the west side of Brantner Ditch. Approximately 2,600 feet north of 160th Avenue, the pipeline turns west. A lateral from the Baseline LE OGPF joins the pipeline at this turn. As the pipeline travels west, it parallels the east-west portion of Havana Street/Lima Street, passing to the south of Stouffer Reservoirs No. 1. A lateral connects from Marcus LD OGPF in Weld County and travels south, crossing 168th Avenue, connecting to the pipeline. The pipeline continues 500 feet west from this lateral junction and turns south, crossing Signal Ditch. The pipeline turns west, paralleling the south side of Signal Ditch, crossing Signal Ditch again and turning

north. Approximately 1,300 feet north of signal ditch, the pipeline turns west. The pipeline turns north before Signal Reservoir Number 2 and passes by the Seltzer LD OGPF. The pipeline turns west at 168th Avenue and parallels the roadway. The pipeline connects to the pipeline segment from Zone B, crosses 168th Avenue, passing into Weld County, traveling north to EWS #6. The majority of this portion of the pipeline is not located along major roadways. By not constructing along these major roadways, traffic impacts during construction of the pipeline will be reduced. This route is closest to Todd Creek residential area, of the Zone A routes. This section primarily runs along parcel boundaries, avoiding bisecting lands, and for portions is collocated with Williams's natural gas pipeline. This pipeline has the most water crossings and has the least engineering feasibility for construction within this zone.

- Route Length: 6.02 miles
- Route Length within unincorporated Adams County: 5.69 miles
- Route Length within unincorporated Weld County: 0.32 mile

3.1.3. Route A-2

This route originates on the eastern side of Zone A at the Brant LD OGPF. The pipeline travels east approximately 1,500 feet, crossing Riverdale Road and Brighton Ditch, turning north near the South Platte River. The pipeline then travels north, crossing 160th Avenue. The pipeline turns west, paralleling the north side of 160th Avenue, turning north just before the east side of Brighton Ditch. The pipeline parallels the east side of Brighton Ditch for approximately 2,800 feet, where it turns west and crosses Brighton Ditch and Brantner Ditch at a 90-degree angle. The pipeline turns north, paralleling the west side of Brantner Ditch, passing by the Baseline LE OGPF, crossing 168th Avenue and into Weld County. The pipeline parallels the north side of 168th Avenue as it travels west. The pipeline crosses CR 21 and passes by the Marcus LD OGPF. The pipeline continues west, crossing CR 19. Just east of the Seltzer LD OGPF, it then turns north. At this turn, a lateral connects Seltzer LD OGPF to the pipeline, crossing 168th Avenue from Adams County. The pipeline then connects to the pipeline section from Zone B that pass into Weld County and travel north to EWS #6. Much of this route is outside of Adams County and farther away from the Todd Creek residential area than Route A-1. The landowners along this route are not all interested in participating in the project, rendering this route unfeasible.

- Route Length: 4.69 miles
- Route Length within unincorporated Adams County: 2.14 miles
- Route Length within unincorporated Weld County: 2.55 miles

3.2. Zone B

3.2.1. Preferred Route

This route originates in the southwest corner of Zone B at the Ivey LC OGPF. The lateral from this OGPF travels east, paralleling the south side of E-470. The pipeline crosses Dig Dry Creek, York Street, an unnamed intermittent stream, German Ditch, Union Pacific Railroad tracks, and Colorado Boulevard at 90-degree angles. The lateral joins the pipeline where it enters from Zone C, then crosses E-470 to the north side of the highway. The pipeline parallels the north side of E-470 to the west, crossing Colorado Boulevard and passing by the Tollway LC OGPF. The pipeline turns north just past the Tollway LC OGPF, connects with a short lateral, and then turns east at the east-west portion of Colorado Boulevard.

The pipeline travels east approximately 1,100 feet before turning north, crossing the east-west portion of Colorado Boulevard. The pipeline travels north, turning east just before German Ditch and passes by B-Farm LD OGPF, connecting with a short lateral. The pipeline parallels the route of German Ditch, crossing two unnamed intermittent streams. The pipeline then turns east and travels on the south side of 160th Avenue. At this turn, a lateral joins the pipeline, originating at the Rio LA OGPF on the southeast corner of 168th Avenue and Colorado Boulevard. The lateral travels south from the OGPF, paralleling the east side of Colorado Boulevard and crossing Big Dry Creek 3 times. The lateral turns east at an unnamed intermittent stream just north of 160th Avenue and crosses German Ditch. Just to the east of German Ditch, the lateral turns south, crossing 160th Avenue and joins the Pioneer mainline. As the pipeline travels east along the south side of 160th Avenue, it crosses Holly Street, an unnamed ditch, and passes by the Ocho LD OGPF and connects with a short lateral. The pipeline continues traveling east along 160th Avenue, crossing Monaco Street, Signal Ditch, and Quebec Street. On the southeast corner of 160th Avenue and Quebec Street, the pipeline turns north, crossing 160th Avenue and paralleling the east side of Quebec Street. As the pipeline travels north it crosses Signal Ditch, turns east at 168th Avenue and parallels the roadway for approximately 1,000 feet, then turns north, crossing 168th Avenue and into Weld County where the pipeline joins with the pipeline portion from Zone A in Weld County and travels north through Weld County to the EWS #6 disposal facility. This route has secured easements, runs along many existing utility corridors, and most efficiently connects all the well pad sites in the areas.

- Route Length: 8.55 miles
- Route Length within unincorporated Adams County: 5.08 miles
- Route Length within unincorporated Weld County: 0.52 mile
- Route Length within the City of Thornton: 1.94 miles

3.2.2. Route B-1

This route originates in the southwest corner of Zone B at the Ivey LC OGPF. The lateral from this OGPF travels east paralleling the south side of E-470. The pipeline crosses Dig Dry Creek, York Street, an unnamed intermittent stream, German Ditch, Union Pacific Railroad tracks, and Colorado Boulevard at 90-degree angles. The lateral joins the pipeline where it enters from Zone C, then crosses E-470 to the north side of the highway. The pipeline parallels the north side of E-470 going west, crossing Colorado Boulevard and passing by the Tollway LC OGPF. The pipeline turns north just past the Tollway LC OGPF, connecting with a short lateral, and then turns east at the east-west portion of Colorado Boulevard. The pipeline travels east approximately 1,100 feet before turning north, crossing the east-west portion of Colorado Boulevard. The pipeline travels north, turning east just before German Ditch and passes by B-Farm LD OGPF, connecting with a short lateral. The pipeline parallels the route of German Ditch, crossing two unnamed intermittent streams. The pipeline then turns east at 160th Avenue and travels east on the south side of the roadway. At this turn a lateral joins the pipeline, originating at the Rio LA OGPF on the southeast corner of 168th Avenue and Colorado Boulevard. The lateral travels south from the OGPF, paralleling the east side of Colorado Boulevard, and crossing Big Dry Creek 3 times. The lateral turns east at an unnamed intermittent stream just north of 160th Avenue and crosses German Ditch. Just to the east of German Ditch, the lateral turns south, crossing 160th Avenue and joins the main pipeline. The pipeline travels east along the south side of 160th Avenue, crossing Holly Street then turning north, crossing 160th Avenue and traveling north along the east side of Holly Street. At this turn, a lateral

from the Ocho LD OGPF at the southwest corner of 160th Avenue and Monaco Street, which crosses an unnamed intermittent stream connects to the pipeline. The pipeline continues north, parallel to the west side of Holly St, crossing 162nd Avenue, German Ditch, and Eagle Shadow Drive at 90-degree angles. At 168th Avenue, the pipeline turns west and crosses Holly Street. At CR 15, the pipeline crosses 168th Avenue into Weld County and travels north along the east side of CR 15. Approximately 1,400 feet north of 168th Avenue, the pipeline turns east and joins with the pipeline portion from Zone A and then travels north through Weld County to the EWS #6 disposal facility. This route follows the west and north borders of a residential development instead of the east and south borders, should there be conflicts within existing utility corridors. This route also has less pipeline within Adams County, but has an increased number of road crossings.

- Route Length: 9.02 miles
- Route Length within unincorporated Adams County: 3.89 miles
- Route Length within unincorporated Weld County: 1.68 miles
- Route Length within the City of Thornton: 3.45 miles

3.2.3. Route B-2

This route originates where the pipeline from Zone C enters Zone B. The pipeline travels west along the south side of E-470, crossing Colorado Boulevard, German Ditch, Union Pacific Railroad tracks, and an unnamed intermittent stream. Approximately 1,000 feet west of the railroad tracks, the pipeline turns north, crossing E-470. At this turn a lateral connects from the Ivey LC OGPF which originates in the southeast corner of Zone B. From this OGPF, the lateral travels east, paralleling the south side of E-470 crossing Big Dry Creek and York St where it joins the pipeline at this turn. The pipeline travels north, crossing an unnamed intermittent stream, 156th Avenue, Big Dry Creek, 160th Avenue, and an unnamed intermittent stream. The pipeline turns east just before 168th Avenue, crosses Colorado Boulevard, and connects with the Rio LA OGPF. The pipeline turns north, crossing 168th Avenue and into Weld County and paralleling the east side of CR 13. Approximately 1,400 feet north of 168th Avenue, the pipeline turns east, crossing Thompson Ditch, Big Dry Creek, and CR 15. Approximately 1,300 feet east of CR 17, the pipeline turns north for 1,200 feet, then turns east, passing German Reservoir Number 12, an unnamed intermittent stream, and CR 17. The pipeline joins with the pipeline portion from Zone A and travels north through Weld County to the EWS #6 disposal facility. This route is unable to connect to the Tollway LC, B-Farm LD, and Ocho LD OGPFs due to engineering constraints, requiring these OGPFs to continue to be served by trucks to transport produced water to EWS #6.

- Route Length: 7.38 miles
- Route Length within unincorporated Adams County: 1.76 miles
- Route Length within unincorporated Weld County: 2.73 miles
- Route Length within the City of Thornton: 2.89 miles

3.3. Zone C

3.3.1. Preferred Route

This route originates where the pipeline from Zone D enters the east side of Zone C. A lateral crosses beneath E-470 connecting the Henderson OGPF to the pipeline. The pipeline travels west, paralleling the

north side of E-470 where it crosses the South Platte River via horizontal directional drilling (HDD), an unnamed intermittent stream, Brantner Ditch and Riverdale Rd. Just west of Riverdale road, the pipeline turns south, crossing E-470 then turning back west, paralleling the south side of E-470, crossing an unnamed intermittent stream. Just west of this unnamed intermittent stream, a lateral comes from the south connecting the Gus LD OGPF to the pipeline. The pipeline continues west along E-470, passing by the Kortum LD OGPF, a lateral comes from the Tower LD OGPF, passing by the Kortum LD OGPF, and connecting to the pipeline. The pipeline continues west, paralleling the south side of E-470, crossing an unnamed intermittent stream, Quebec Street, two unnamed intermittent streams, Todd Creek, Holly Street, Signal Ditch and reaching the west side of Zone C. This route is the most direct route, following the E-470 right-of-way for the entirety of the zone. This route has the best approach for the HDD beneath the South Platte River.

- Route Length: 6.29 miles
- Route Length within unincorporated Adams County: 3.19 miles
- Route Length within the City of Brighton: 2.64 miles
- Route Length within the City of Thornton: 0.45 mile

3.3.2. Route C-1

This route originates where the pipeline from Zone D enters the east side of Zone C. A lateral crosses beneath E-470 connecting the Henderson OGPF to the pipeline. The pipeline travels west, paralleling the north side of E-470, where it crosses the South Platte River via HDD, an unnamed intermittent stream, Brantner Ditch, Riverdale Road, and the same unnamed intermittent stream five times. A lateral from the south crosses E-470, connecting the Kortum LD OGPF, Gus LD OGPF, and Tower LD OGPF. The pipeline continues west, paralleling the south side of E-470, crossing an unnamed intermittent stream, Quebec Street, two more unnamed intermittent stream, Todd Creek, Holly Street, and Signal Ditch and reaching the west side of Zone C. This route has an increased number of waterway crossings and is on the opposite side of E-470 from the existing utility corridor.

- Route Length: 6.54 miles
- Route Length within unincorporated Adams County: 2.99 miles
- Route Length within the City of Brighton: 0.43 mile
- Route Length within the City of Thornton: 3.12 miles

3.3.3. Route C-2

This route originates where the pipeline from Zone D enters the east side of Zone C. The pipeline crosses from the north to the south side of E-470, turning west and paralleling the south side of E-470. At this junction, a lateral extends southwest that connects the Henderson OGPF to the pipeline. The pipeline travels west, paralleling the south side of E-470, where it crosses the South Platte River, an unnamed intermittent stream, Brantner Ditch, Riverdale Road, and an unnamed intermittent stream. Just west of this unnamed intermittent stream, a lateral from the south connects the Gus LD OGPF to the pipeline. The pipeline continues west along E-470, passing by the Kortum LD OGPF, a lateral comes from the Tower LD OGPF, passing by the Kortum LD OGPF, and connecting to the pipeline. The pipeline continues west, paralleling the south side of E-470, crossing an unnamed intermittent stream, Quebec

Street, two unnamed intermittent stream, Todd Creek, Holly Street, Signal Ditch and reaching the west side of Zone C. This route does not have the best approach for the HDD of the South Platte River, but reduces the number of HDDs needed under E-470.

- Route Length: 6.1 miles
- Route Length within unincorporated Adams County: 3.05 miles
- Route Length within the City of Brighton: 0.42 mile
- Route Length within the City of Thornton: 2.62 miles

3.4. Zone D

3.4.1. Preferred Route:

This route originates at the Prairie LE OGPF on the eastern side of Zone D. The pipeline goes west from the OGPF paralleling the north side of 136th Avenue. The pipeline passes by the Rico OGPF on the northeast corner of 136th Avenue and Potomac Street. The pipeline crosses to the south side of 136th Avenue at the same location the Fulton Ditch crosses 136th Avenue. The pipeline continues west, paralleling 136th Avenue, and crossing the Fulton Lateral Ditch at a 90-degree angle. The pipeline crosses to the north side of 136th Avenue at the same location Third Creek crosses 136th Avenue. The pipeline continues west for approximately 1,000 feet and turns north approximately 400 feet before turning west again for 900 feet, passing by the Schaefer OGPF, turning south and the turning west to again parallel the north side of 136th Avenue. The pipeline then crosses the Union Pacific Railroad tracks, Second Creek, and U.S. Highway 85. The pipeline continues west, passing by the Sharp OGPF, then crossing Brighton Road at the western side of Zone D. This is the shortest pipeline route, presenting the most engineering feasibility, and is collocated with the Boardwalk Pipeline along 136th Avenue.

- Route Length: 2.73 miles
- Route Length within unincorporated Adams County: 1.84 miles
- Route Length within the City of Brighton: 0.89 mile

3.4.2. Route D-1

This route originates at the Prairie LE OGPF on the eastern side of Zone D. The pipeline goes west from the OGPF, paralleling the north side of 136th Avenue. The pipeline passes by the Rico OGPF on the northeast corner of 136th Avenue and Potomac Street. At the Fulton Lateral Ditch, the pipeline turns north, paralleling the east side of Fulton Lateral Ditch. Approximately 3,100 feet north of 136th Avenue, the pipeline turns west, crossing Fulton Lateral Ditch and Potomac Street. The pipeline turns south, paralleling the east side of the Union Pacific Railroad tracks for approximately 1,800 feet, crossing Third Creek before turning west. The pipeline crosses the Union Pacific Railroad tracks and U.S. Highway 85. A lateral to the south connects to the Schaefer OGPF to this turn. The pipeline continues west from the U.S. Highway 85 crossing, turning south just before Brighton Road. The pipeline crosses Second Creek and passes by the Sharp OGPF. The pipeline turns west, paralleling the north side of 136th Avenue, crossing Brighton Road to reach the west side of zone D. This route is collocated with the Boardwalk Pipeline from Prairie LE OGPF to the junction with the lateral for the Schaefer OGPF, which presents ease for land use designation of a new pipeline. This route is not feasible from an engineering standpoint and would result in more disturbance because it is longer than the preferred route.

- Route Length: 4.31 miles
- Route Length within unincorporated Adams County: 3.41 miles
- Route Length within the City of Brighton: 0.90 mile

3.4.3. Route D-2

This route originates at Prairie LE OGPF on the eastern side of Zone D. The pipeline heads west, paralleling the north side of 136th Avenue for approximately 1,000 feet, then turns north. The pipeline turns west at 144th Avenue, paralleling the south side of 144th Avenue and crosses Country Hills Drive and Fulton Ditch. The pipeline turns south on the east side of the Fulton Ditch Lateral and parallels the ditch for 2,000 feet. The pipeline turns west, crossing Fulton Lateral Ditch and Potomac Street. A lateral extends from the south, connecting the Rico OGPF at this turn. After traveling west, the pipeline turns south, paralleling the east side of the Union Pacific Railroad tracks for approximately 1,800 feet, crossing Third Creek before turning west. The pipeline crosses the Union Pacific Railroad tracks and U.S. Highway 85. There is a lateral that connects from the south from the Schaefer OGPF to this turn. The pipeline continues west from the U.S. Highway 85 crossing, turning south just before Brighton Road. The pipeline crosses Second Creek and passes by the Sharp OGPF. The pipeline turns west, paralleling the north side of 136th Avenue, crossing Brighton Road to reach the west side of Zone D. This route is the longest within Zone D and is not feasible from an engineering standpoint because the minimum pipeline pressure requirements cannot be attained along a longer route.

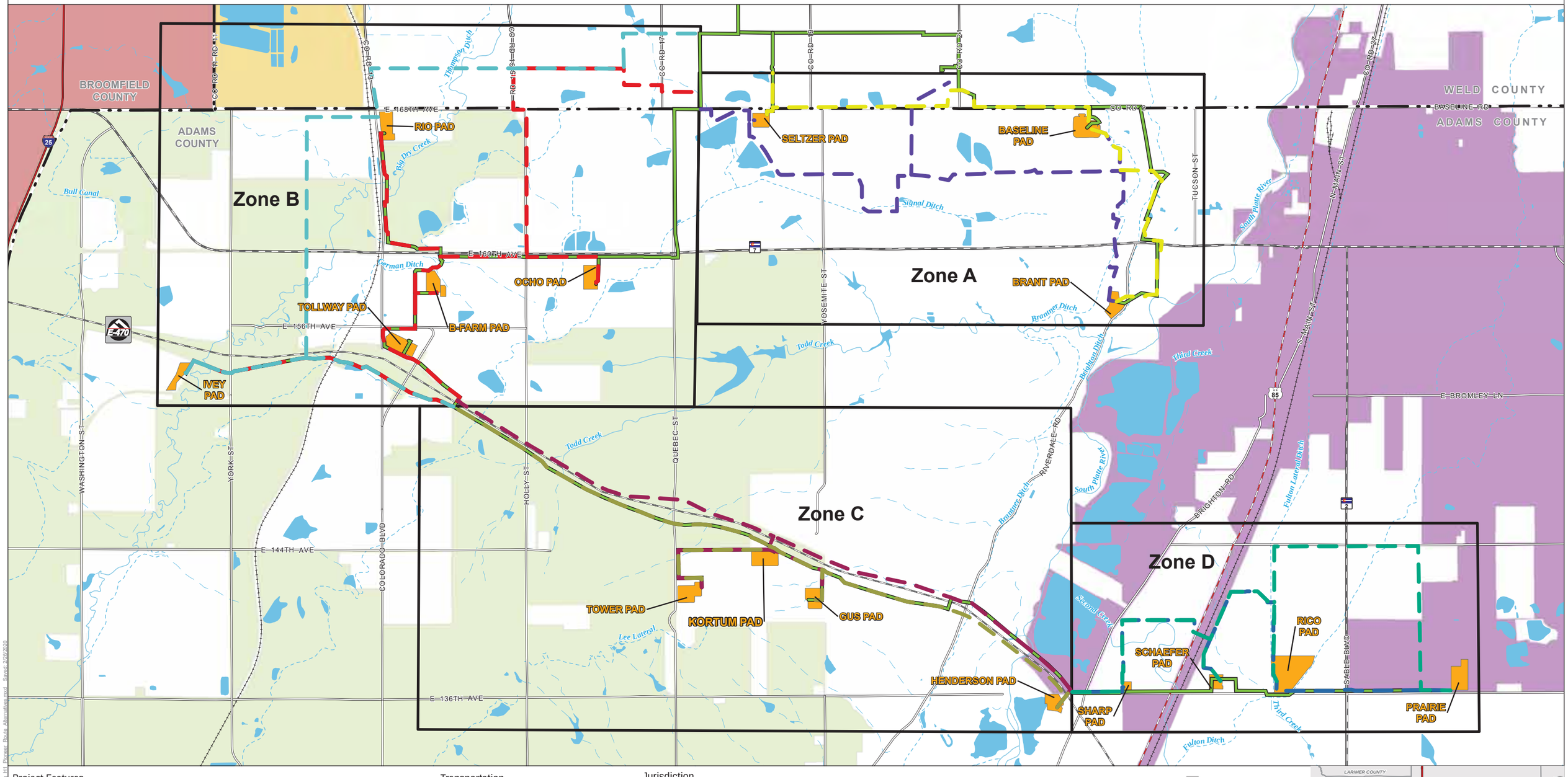
- Route Length: 5.58 miles
- Route Length within unincorporated Adams County: 4.70 miles
- Route Length within the City of Brighton: 0.88 mile

Table 1:
dams County Pipeline Length by Zone by Municipality

Route Name	Total Length (miles)	Length within Unincorporated Adams Co. (miles)	Length within Unincorporated Weld Co. (miles)	Length within Brighton (miles)	Length within Thornton (miles)
A-Preferred	3.80	2.13	1.67	0	0
A-1	6.02	5.69	0.32	0	0
A-2	4.69	2.14	2.55	0	0
B-Preferred	8.55	5.08	0.52	0	1.94
B-1	9.02	3.89	1.68	0	3.45
B-2	7.38	1.76	2.73	0	2.89
C-Preferred	6.29	3.19	0	2.64	0.45
C-1	6.54	2.99	0	0.43	3.12
C-2	6.10	3.05	0	0.42	2.62
D-Preferred	2.73	1.84	0	0.89	0
D-1	4.31	3.41	0	0.90	0
D-2	5.58	4.70	0	0.88	0

PIONEER PRODUCED WATER PIPELINE PROJECT

Figure H-1: Adams County Alternative Routes



Project Features
- Preferred Route
- Oil and Gas Production Facility

Routes Considered and Eliminated
- Route A-1
- Route A-2
- Route B-1
- Route B-2
- Route C-1
- Route C-2
- Route D-1
- Route D-2

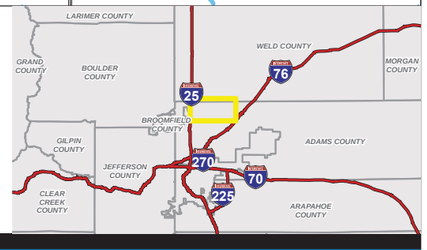
Transportation
- Interstate
- U.S. Highway
- Major Local Road
- Railroad

Jurisdiction
- Brighton
- Broomfield
- Northglenn
- Thornton
- County Boundary

0 0.5 1 Miles

Scale is 1:20,000 when printed at 22x34

NOT FOR CONSTRUCTION



Sources: CDOT 2015, US Census 2019, BTS 2019, NHD 2019

The route shown in this figure is a graphical representation and may not show exact locations. The pipeline alignment is subject to change based on final engineering.

TETRA TECH

DEVELOPMENT AGREEMENT

THIS DEVELOPMENT AGREEMENT ("Agreement") is made and entered into by and between the **COUNTY OF ADAMS**, a political subdivision of the State of Colorado, hereinafter called ("County"), and **Pioneer Water Pipeline, LLC**, a Delaware limited liability company, 2015 Clubhouse Dr, Suite 201, Greeley, CO 80634, hereinafter called ("Developer"). County and Developer may be referred to in this Agreement collectively as “Parties” or singularly as “Party.”

WITNESSETH:

WHEREAS, Developer desires to construct approximately 19.2 miles of 4- to 12 inch-diameter high-density-polyethylene (HDPE) produced water gathering pipelines and associated appurtenances in Adams County, Colorado, as shown in the alignment sheets in Exhibit A; more particularly described in that certain Conditional Use Permit (“CUP”) Application dated February 28, 2020; and

WHEREAS, on February 28, 2020, Developer submitted an application for a CUP to Adams County in accordance with the requirements outlined in Chapter 2 of the Adams County Development Standards and Regulations ("the Regulations"), the CUP Checklist, and requested submittal criteria from the Adams County Areas and Activities of State Interest ("AASI") Checklist; and

WHEREAS, Developer will acquire, if it has not already done so, all necessary right-of-way easements and temporary construction easements to utilize certain real property in the County of Adams, State of Colorado; and

WHEREAS, the County has designated its future road expansion plans in the Adams County Transportation Plan adopted November 2012 ("Transportation Plan"); and

WHEREAS, the County and Developer have planned and designed the Project, so it will not prohibit future development, and so that it will not add cost to the County's future infrastructure plans to support development.

NOW, THEREFORE, in consideration of the foregoing, the parties hereto promise, covenant, and agree as follows:

I. DEVELOPER'S OBLIGATIONS:

1. Pre-Construction Activities. Prior to site disturbance and commencing construction in the County, Developer Shall:

   a. Apply for the applicable construction permits.

   b. Prepare a Storm Water Management Plan. Storm Water Best Management Practices (" BMPs") will be implemented for the construction phase to capture and treat onsite Storm Water runoff in accordance with the requirements for the Storm Water Management Plan for the Project.

   c. Secure applicable local, state, and federal permits for the Project and submit copies of these permits to the County.

   d. Secure Adams County Right-of-Way permits prior to constructing crossings, which shall not be unreasonably withheld or delayed.

   e. Record all executed easements and property deeds for the Project with the County.

   f. Contact and use commercially reasonable efforts to work with Xcel Energy and United Power regarding any possible encroachment the Project may have on Xcel Energy's or United Power's pipeline(s) or related facilities.

   g. Submit evidence (e.g. permit number) of approved Xcel Energy license agreements to the County.

   h. Submit evidence (e.g. permit number) of approved Colorado Department of Transportation ("CDOT") Utility Permit for the Crossing of U.S. Highway 85, State Highway 7, and State Highway 2 to the County.

   i. Submit evidence (e.g. permit number) of the approved E-470 Public Highway Authority ("E-470") Pipeline Crossing Permit for the crossing of E-470 to the County

   j. Submit evidence (e.g. permit number) of the approved Union Pacific Railroad Crossing/Encroachment Permit for utilities that cross or follow along the ROW.

   k. Submit engineering plans for an approximately 10-foot-wide permanent easement plus an additional 30-foot-wide temporary easement for a total construction corridor of 40 feet in width to be designed and constructed in accordance with Chapter 7 of the Adams County Development Standards and Regulations

2. Construction Activities. During construction, Developer shall:

   a. Construct the Project in accordance with the CUP.

   b. Manage Stormwater in accordance with a stormwater management plan ("SWMP") prepared under the Colorado Department of Public Health and Environment ("CDPHE") Colorado Discharge Permitting System ("CDPS") Permit and in accordance with the Clean Water Act National Pollution Discharge Elimination System ("NPDES") regulations and Adams County's Grading Erosion and Sediment Control standards. Stormwater BMPs will be implemented for the construction phase to capture and treat onsite Storm Water runoff in accordance with the requirements for the SWMP.

   c. Operate at the Project site only from 7:00 AM to 7:00 PM, Monday through Saturday. Construction may occur on Sundays and other hours outside 7:00 AM to 7:00 PM timeframe on an as-required basis during inclement weather, during hydrostatic testing, horizontal directional drilling ("HDD"), and emergency situations that would cause Developer to be out of compliance with any applicable local, state, or federal permit. The County Director of Community and Economic

Development may extend the hours and days of operation if Developer makes a request in writing and demonstrates sufficient need.

d. Comply with guidelines of Section 106 of the National Historic Preservation Act of 1966 in locations that have been identified as federally regulated within the County. Comply with State of Colorado Historical, Paleontological, and Archeological Resources Act of 1973 (C.R.S. §§ 24-80-401 to 410) on all identified state lands within the County. All best management practices and avoidance measures proposed within the approved CUP on lands that are state and federally regulated by the above listed laws will be enforced.

e. Comply with the terms of the Project's Air Pollution Emissions Notice ("APEN") issued by CDPHE, if an APEN is required.

f. Comply with C.R.S. § 42-4-1407, covering loads for all hauling/construction trucks.

g. Be responsible for the cleanliness and safety of roadways adjacent to the Project in the event there are any issues related to the Project during construction. If at any time these roadways are found to be dangerous or not passable due to debris or mud caused by Project activities, the County may require the Developer to cease Project operations immediately in the affected area and clear the roadway of any and all debris or mud. If required by the County, the Project shall not resume until the County deems the roadway conditions acceptable. If the Developer fails to keep the adjacent roadways clean and free from debris, Adams County Transportation Department has the option to perform the required clean up and bill clean up charges directly to the Developer.

h. Be responsible for repairing County infrastructure that is damaged as a result of the construction from the Project. County will make a reasonable effort to provide any locations of County infrastructure to Developer within 30 days of CUP approval. Repairs shall occur as soon as possible, but no later than six (6) months following construction completion, unless an extension is granted by the County for extenuating circumstances. The Developer may submit evidence of the condition of the County's infrastructure at the start and completion of construction in order to demonstrate the pre-construction condition and the post-construction condition of the infrastructure.

i. Remove and dispose of fluid spills caused by the project if applicable, such as hydraulic oil from maintenance of equipment, at a facility permitted for such disposal.

j. Convey complaints Developer receives concerning off-site impacts and the resolution of those complaints to the Adams County Community and Economic Development Department. Off-site impacts shall be responded to and resolved by Developer. The Adams County Community and Economic Development Department will be the final decision maker regarding the resolution of noise complaints or any other off-site impacts, provided that Developer is provided notice and given an opportunity to be heard. Excessive complaints that are not resolved to the satisfaction of the County may be justification for a Show Cause Hearing before the Adams County Board of County Commissioners.

k. Ensure that construction vehicles have a backup alarm that complies with Occupational Safety and Health Administration requirements, 29 CFR 1926.601(b)(4) and 1926.602(a)(9), and/or other remedies (such as flagmen) to minimize noise as approved by the County.

l. Notify the County prior to commencing snow removal operations within the County's right-of-way. The Developer shall be responsible for damages to the right-of-way caused by these activities and shall repair damages at its expense within 60 days of receiving notice from the County.

m. Screen storage or staging areas from adjacent residential properties within 100 feet.

n. Comply with all applicable local, state, and federal requirements during the course of the project.

o. Implement the following BMPs outlined in the Biological Resources Assessment:

I. Horizontal directional drilling shall be used to avoid impacts to wetlands and waterbodies to the extent practicable and in accordance with U.S. Army Corps of Engineers requirements.
II. Raptor and bald eagle surveys should be conducted by a qualified biologist prior to disturbance.
III. If initial land disturbance is anticipated from March 15th to September 31st, a survey for potential burrowing owl habitat will be conducted. If potential habitat is found, surveys will be conducted in accordance with the Colorado Parks and Wildlife (CPW) protocols prior to the start of construction.
IV. If construction is planned to occur between April 1st to July 31st, field reconnaissance of potential mountain plover habitat should be conducted prior to disturbance.
V. In areas of trenching, trenches left overnight shall be covered or a means of egress provided for any wildlife that may enter the trench. Trenches should be checked for wildlife daily and if a species listed as Federal- or State- threatened or endangered is found or suspected, work should stop while a qualified biologist is contacted to relocate the animal.

p. Implement the following Tri-County Health Department water well mitigation measures:

I. If trench dewatering is necessary, the water will be pumped and discharged to alluvial/colluvial sediments close to the stream channel.
II. If discharge of groundwater is necessary during construction, Developer agrees to obtain a discharge permit from CDPHE, Water Quality Control Division.

3. Design Requirements.

a. The Project will be designed to meet or exceed the minimum safety standards contained the Colorado Oil and Gas Conservation Commission Part 1100 rules, as applicable, and national engineering design codes for pipelines set forth by the American Society of Mechanical Engineers.

b. Pipeline burial depths will meet or exceed federal, state, and applicable engineering standards. The Pipelines will be buried with a minimum of 48-inches of cover where practical.

c. Ensure the pipeline is located in easements on private property or County owned property and County road crossings shall be as near as possible to right angles. This effective placement of the Pipeline complies with required structure setbacks per 2012 Transportation Plan.

4. Operational Requirements.

a. The Project will be operated in accordance with the safety standards contained the Colorado Oil and Gas Conservation Commission (COGCC) Part 1100 rules.

b. The Project will be operated in accordance with all applicable local, state, and federal codes, laws, and regulations, including but not limited to CDOT and CDPHE.

c. The Project will utilize an integrity management program as detailed in the COGCC Part 1100 rules.

5. Post-Construction and Maintenance Requirements.

a. Developer agrees to restore disturbed County-owned lands in compliance with the requirements of applicable easement agreements. In the event that reseeding is unsuccessful in the first growing season, Developer agrees to comply with the terms of the easement agreements during the subsequent growing season. The County may grant an extension for good cause, in writing, in the event of unforeseen circumstances.

b. Developer agrees to restore disturbed private property in accordance with the applicable easement agreements. In the event that reseeding is unsuccessful in the first growing season, Developer agrees to comply with the terms of the easement agreements to restore the land. The

County may grant an extension for good cause, in writing, in the event of unforeseen circumstances.

c. The Developer also agrees that the approval of encroachment agreement requests for parking lots and driveways on private property shall not be unreasonably or arbitrarily withheld, in accordance with the terms of the easement agreements for the Project, so long as such encroachment requests do not affect Developer's ability to safely operate its Pipeline.

d. Developer agrees that it will not disrupt or damage the functionality of existing drainage facilities.

e. Developer agrees to submit "as built" construction drawings to the Adams County Community and Economic Development Department and Public Works Department within 180 days of construction completion in accordance with the procedures established by the County.

f. Developer agrees to submit emergency contact information, emergency response plans, and final maps of the Project, including associated Pipeline components, to the local fire districts encompassing the Project and to the Adams County Office of Emergency Management before commencing operation of the Pipeline. The Developer shall comply with other requests for information from the Adams County Office of Emergency Management in accordance with local, state, and federal law.

g. Maintenance of the Project will follow guidelines set forth in Developer's operations and maintenance procedures, which meet or exceed regulatory requirements. Maintenance activities associated with the Pipeline and permanent easement include, the following:
   - Implement a damage prevention program, including observation of any construction activities by others on or near the permanent easement;
   - Participate in the State of Colorado's one-call program and responding to one-calls;
   - Install and maintain pipeline markers;
   - Inspect block valves;
   - Inspect crossings by other pipelines, highways, railroads, and utilities;
   - Inspect and maintain safety, control, mechanical, and electrical equipment;
   - Maintain communication equipment; and

6. Development Impact Fees. There are no development impact fees associated with this Project.

7. Guarantee of Compliance. Developer herby agrees that, should it fail to comply with the terms of this Agreement through no fault of Adams County, the County is entitled to obtain from the Colorado State District Court for the Seventeenth Judicial District a mandatory injunction requiring said Developer to comply with the terms of this Agreement. Prior to the County seeking such an injunction, Developer will be provided the opportunity to cure any default in accordance with the terms set forth herein. Developer further agrees that failing to comply with the requirements set forth in this Agreement may be justification for a Show Cause Hearing where the CUP Permit may be revoked.

8. Successors and Assigns. The rights granted herein may be assigned in whole or in part, and the terms, conditions, and provisions of this Agreement shall be deemed a covenant running with the real property in perpetuity and shall be binding upon the heirs, executors, personal representatives, successors, and assigns of Developer and of the County.

II. COUNTY'S OBLIGATIONS:

Except as expressly set forth herein, the County shall have no obligations associated with this Agreement.

III. GENERAL PROVISIONS:

1. No Third-Party Beneficiaries. This Agreement is intended to describe and determine such rights and responsibilities only as between the Parties hereto. It is not intended to and shall not be deemed to confer rights or responsibilities to any person or entities not named hereto.

2. Notices. Any and all notices, demands or other communications desired or required to be given under any provision of this Agreement shall be given in writing and delivered personally or sent by registered or certified mail, return receipt requested, postage prepaid or by email address as follows:

   To Developer:
   PIONEER WATER PIPELINE, LLC
   Attn: Land Manager
   600 17th St., Suite 725-S
   Denver, CO 80202

   To Adams County:
   Director, Adams County Community and Economic Development
   4430 South Adams County Parkway, 1st Floor, Suite W2000A
   Brighton, CO 80601

   With a copy to:
   Adams County Attorney
   4430 South Adams County Parkway, 5th Floor, Suite C500B
   Brighton, CO 80601

3. Amendments. Should any changes to the CUP be proposed by Developer before, during or after completion of the Project, Developer shall submit the details of those changes to the Adams County Community and Economic Development Director for a determination as to whether those changes constitute a Major or Minor Amendment in accordance with the Regulations.

   This Agreement may only be modified amended, changed or terminated in whole or in part by a separate agreement in writing duly authorized and executed by the Parties hereto with the same formality, and subject to the same statutory and regulatory requirement, as this Agreement.

4. Controlling Law. This Agreement and its application shall be construed in an accordance with the laws of the State of Colorado.

5. Default. If either Party is in default under this Agreement, the non-defaulting Party shall provide written notice to said defaulting Party at the address provided in Section 2 immediately above. The defaulting Party shall have 30 days to cure the default, unless an extension is granted in writing by the non-defaulting Party for good cause. The non-defaulting Party may seek all remedies available pursuant to the Agreement and under the law.

6. Costs and Fees. In the event of any litigation arising out of this Agreement, the Parties agree that each Party will pay its own costs and fees.

DEVELOPER:

PIONEER WATER PIPELINE, LLC
a Colorado limited liability company

_____

By: Jim Goddard
Title: President

ACKNOWLEDGMENT

STATE OF COLORADO)
) ss.
COUNTY OF ADAMS)

The foregoing instrument was acknowledged before me this_____ day of_____2020, by Jim Goddard, as President, on behalf of Pioneer Water Pipeline, LLC, Colorado limited liability company.

Witness my hand and official seal.

_____
Notary Public
State of Colorado

My Commission Expires: _____

My Commission Number: _____

APPROVED BY resolution at the meeting of_____, 2020.

ATTEST:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____
Clerk to the Board

_____
Chairperson

Approved as to form:

_____
Adams County Attorney's Office

EXHIBIT “A”

Pipeline Alignment Sheets

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2. Development Review Team

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, CO 80601-8204
PHONE 720.523.6800
FAX 720.523.6998

Development Review Team Comments

Date: 4/6/2020
Project Number: RCU2020-00004
Project Name: PIONEER WATER PIPELINE PROJECT

Commenting Division: Planner Review
Name of Reviewer: Greg Barnes
Date: 04/06/2020
Email: gjbarnes@adcogov.org

Resubmittal Required

1. Throughout the document, please update our department name to "Community and Economic Development".
2. In your resubmittal, please include a written response to the public comment for Mr. Lloyd. I will share your reply with him.

Commenting Division: ROW Review
Name of Reviewer: Eden Steele
Date: 03/27/2020
Email:

Complete

ROW1: Applicant acknowledged in Section 3.7.3 of the application that "Pioneer would obtain an Adams County ROW crossing permit prior to construction, and the pipeline would only cross county road ROWs at or near a perpendicular angle. In any segment of the Project that is parallel to an Adams County ROW, the pipeline will be constructed a minimum of five (5) feet from the edge of the maximum future ROW width, as designated in the Adams County 2012 Transportation Plan." Compliance with this requirement will be confirmed prior to construction/utility permit issuance. Applicant should include pipeline setbacks from Adams County roadway centerlines on the final set of construction documents.

Page 1 of 3

Commenting Division: Development Engineering Review

Name of Reviewer: Eden Steele

Date: 03/27/2020

Email:

Complete

ENG1: No floodplain use permit required for underground utilities.

ENG2: Applicant is aware an Adams County SWQ Permit will be required prior to construction/utility permit issuance. The applicant can contact Juliana Archuleta, the County's Stormwater Program Manager, to inquire about obtaining a SWQ Permit. Ms. Archuleta can be contacted at 720-523-6869 or by email at mjarchuleta@adcogov.org.

ENG3: Prior to construction/utility permit issuance, the applicant should ensure the pipeline elevation and alignment does not conflict with Mile High Flood District plans when designed plans are available. There are some proposed detention/ water quality facilities and associated drainage infrastructure within the proposed pipeline alignment in the following locations:
1) Along E 136th Ave east of Potomac St.
Brighton Watershed Area – Brighton Watershed Tributary to South Platte River – Outfall Systems Planning – Preliminary Design Report; Prepared for Urban Drainage and Flood Control District, Adams County, and the City of Brighton; Dec 1998
2) Along northern property line of Parcel #: 0157121000016
Todd Creek Area – Todd Creek and DFA 0052 Watersheds Outfall System Planning Study – Preliminary Design Report; Prepared for Urban Drainage and Flood Control District, Adams County, and City of Thornton; Dec 2003

ENG4: The County will review all construction documents via the Engineering Review process to ensure County roadway crossings meet requirements set forth in Chapter 7 of the Adams County Development Standards and Regulations. Pipeline setbacks from roadway centerlines should be included on the construction plans. Compliance with County environmental and right-of-way requirements will be confirmed prior to construction/utility permit issuance.

Commenting Division: Environmental Analyst Review

Name of Reviewer: Katie Keefe

Date: 03/25/2020

Email:

Resubmittal Required

Conditions Precedent

1: In accordance with Colorado Parks and Wildlife (CPW) recommendations and as specified in the project's Resources Review, applicant will provide documentation of seasonal raptor nest surveys for active nests prior to construction activities commencing between October 15 and July 31.

2: The applicant will provide documentation of coverage under the USACE Nationwide Permit 12 prior to construction of pipeline segments crossing WOTUS where HDD is not feasible and for which restoration to antecedent conditions is required.

3. The applicant must provide documentation that a Construction Permit, if required, has been obtained and documentation of APEN submittal to Colorado Department of Public Health and Environment.

Conditions

ENV1. The applicant shall adhere to CPW Recommended Survey Protocol and Actions to Protect Nesting Burrowing Owls for construction activities commencing between October 15 and July 15.

ENV2. The applicant shall adhere to all nuisance impact mitigation measures as identified in Section 3.11.9 of its conditional use permit application.

ENV3. To minimize fugitive dust emissions, the applicant shall cease all earthmoving activities at any time wind speeds exceed 25 mph.

Comments

ENV1. An Emergency Response Plan, as requested, was not included with the conditional use permit application documentation. Please provide a copy of the project Emergency Response Plan and documentation that a copy has been provided to the County Office of Emergency Management as the DERA.

Page 3 of 3

Responses to Comments from Adams County

Planner Review

1. Comment noted. The department name has been updated in a revised version of the text provided with this resubmittal.

2. Please find the written response included in this resubmittal following Mr. Lloyd's comments.

ROW Review

ROW1:

Pioneer will ensure that the pipeline will only cross county road ROWs at or near a perpendicular angle and that any segment of the pipeline constructed parallel to an Adams County ROW will be constructed a minimum of five (5) feet from the edge of the maximum future ROW width and will include the setbacks from the roadway centerlines in the final alignment sheets. Pioneer understands that Adams County will confirm compliance with this requirement prior to construction/utility permit issuance. Pipeline setbacks from Adams County roadway centerlines will be provided on the final set of construction documents.

Development Engineering Review

ENG 1

Comment noted.

ENG 2

Pioneer will apply for the Adams County SWQ Permit prior to construction within the Adams County MS4 permitted area.

ENG 3

Pioneer has reviewed the Mile High Flood District plans along East 136 Avenue East of Potomac Street and at the Todd Creek area along the northern property line of Parcel 0157121000016. No conflict between the Pioneer Water Pipeline and the Mile High Flood District Plans is anticipated.

ENG 4

Pioneer understands that compliance with Adams County environmental and ROW requirements will be confirmed prior to construction/utility permit issuance.

Environmental Analyst Review

Conditions Precedent

1. Pioneer will provide documentation of seasonal raptor nest surveys between October 15 and July 31, prior to construction activities commencing.

2. Pioneer will provide documentation of coverage under the USACE Nationwide Permit 12 or other Nationwide Permit prior to construction commencing if applicable.

3. Pioneer will provide documentation that a Construction Permit has been obtained if necessary and will provide documentation of APEN submittal to CDPHE prior to construction.

Conditions
Pioneer notes these conditions of approval.

Comments

ENV 1

A draft Emergency Response Plan (ERP) and documentation the ERP is included with this resubmittal for review by the Adams County Office of Emergency Management. The ERP will be finalized following construction to ensure accuracy based on final engineering.

3. Colorado Parks and Wildlife

COLORADO
Parks and Wildlife
Department of Natural Resources

Northeast Regional Office
6060 Broadway
Denver, CO 80216
P 303.291.7227

March 30, 2020

Mr. Greg Barnes
Community & Economic Development Department
4430 South Adams County Parkway, 1st Floor, Suite W2000B
Brighton, CO 80601-8218

RE: Pioneer Produced Water Pipeline CUP, RCU2020-00004

Dear Mr. Barnes:

Thank you for the opportunity to comment on the proposed conditional use permit for the construction and operation of approximately 19.2 miles of new produced water gathering pipelines within Adams County. The 19.2 miles of pipeline will reduce the impacts to the surrounding communities to oil and gas exploration by transferring the transportation of produced water to pipelines from trucks within Adams County and Weld Counties. The oil and gas production facilities are operated by Great Western Petroleum, LLC. The proposed pipeline will be in unincorporated Adams County and within the cities of Brighton and Thornton, on various parcels of private and public property. The project will cross various state highways, county roads, railroads, wetlands, streams and other existing infrastructure.

The mission of Colorado Parks and Wildlife (CPW) is to perpetuate the wildlife resources of the state, to provide a quality state parks system, and to provide enjoyable and sustainable outdoor recreation opportunities that educate and inspire current and future generations to serve as active stewards of Colorado's natural resources. Our goal in responding to land use proposals such as this is to provide complete, consistent, and timely information to all entities who request comment on matters within our statutory authority. Current CPW policy directs our efforts towards proposals that will potentially have high impacts to wildlife and wildlife habitat. The emphasis of CPW's concerns is on large acreages, critical habitats, wildlife diversity, and impacts to species of special concern, or those that are state or federally endangered.

On a vast majority of the parcels, CPW would expect to find small ground dwelling mammals including prairie dogs and passerine birds. Due to the low availability of undeveloped habitat surrounding those parcels, impacts of the development, as proposed, may be characterized as minimal. CPW recommends that the developer minimize the amount of time trenches are open and the length of trenches are in order to reduce impacts to ground dwelling mammals. CPW also recommends that the developer consider implementing a method for ground dwelling mammals to escape after falling into an open trench. However, several parcels are in close proximity to active bald eagle nests, wetlands and streams. CPW expects that there may be potential impacts to those parcels.

Burrowing Owls

If prairie dog towns are present on the sites or if prairie dogs establish themselves on the property prior to development - CPW recommends that a burrowing owl survey be conducted prior to earth moving. Burrowing owls live on flat, treeless land with short vegetation, and nest underground in burrows dug by prairie dogs, badgers, and foxes. These raptors are classified as a state threatened species and are protected by state and federal laws, including the Migratory Bird Treaty Act.

These laws prohibit the killing of burrowing owls or disturbance of their nests. Therefore, if any earth-moving will occur between March 15th and October 31st, a burrowing owl survey should be performed. Guidelines for performing a burrowing owl survey may be obtained by visiting the CPW website at http://cpw.state.co.us or by calling the CPW Denver Region Office at (303) 291-7227.

Natural Vegetation, Wetlands and Water Sources

CPW recommends that land within the project area be restored to native habitat if possible. To improve wildlife habitat after construction, CPW recommends using native plant species along the project area. CPW also recommends planting trees, shrubs, and grasses so that they are mixed within the landscape. A landscape that has a good mix of trees, grasses, and shrubs is more beneficial to wildlife than a landscape with all trees in one area and all grasses and shrubs in others.

If heavy equipment is used near any water source (that was used in another stream, river, lake, reservoir, pond, or wetland) one of the following disinfection practices is necessary prior to construction to prevent the spread of New Zealand mud snails, zebra mussels, quagga mussels, whirling disease, and any other aquatic invasive species into this drainage. These practices are also necessary after project completion, prior to this equipment being used in another stream, river, lake, reservoir, pond, or wetland:

- Remove all mud, plants, debris from equipment (tracks, turrets, buckets, drags, teeth, etc.) and spray/soak equipment in a 1:15 solution of Quat 4 or Super HDQ Neutral institutional cleaner and water. Keep equipment moist for at least 10 minutes **OR**
- Remove all mud, plants and debris from equipment (tracks, turrets, buckets, drags, teeth, etc.) and spray/soak equipment with water greater than 140 degrees F for at least 10 minutes.
- Clean hand tools, boots, and any other equipment that will be used in the water with one of the above options as well. Do not move water from one water body to another. Be sure equipment is dry before use.

Since the project is proposing the use of horizontal directional drilling to cross wetlands and streams, CPW recommends that the developer consult with the United States Army Corps of Engineers at (720) 922-3857 about specific requirements or permits that USACE may require prior to the start of construction.

Bald Eagles

As there two different active bald eagle nests within a half mile of the several parcels, CPW recommends that Great Western Petroleum, LLC adhere to the Recommended Buffer Zones and Seasonal Restriction Guidelines. Great Western Petroleum, LLC should contact CPW for specific nest locations. These guidelines are designed to minimize nest abandonment while allowing for potential development to continue. These guidelines are as follows:

- No surface occupancy within a quarter of a mile radius of any active nest.
- No human encroachment within a half of a mile radius of any active nest between November 15 to July 31.
- Any potential work that needs to be completed within the half of a mile buffer should be limited to August 15 through October 15.
- If the Developer cannot adhere to the Recommended Buffer Guidelines, the Developer should consult with the United States Fish and Wildlife Service Mountain-Prairie Region at (303) 236-8171.

A copy of the Recommended Buffer Zones can be obtained by visiting the CPW website at https://cpw.state.co.us/Documents/WildlifeSpecies/LivingWithWildlife/RaptorBufferGuidelines2008.pdf or by calling the CPW Denver Region Office at (303) 291-7227.

Thank you again for the opportunity to comment on the proposed Pioneer Produced Water Pipeline in Adams County, CO. Please do not hesitate to contact us again about ways to continue managing the landscape in order to maximize wildlife value while minimizing potential conflicts. If you have any further questions, please contact District Wildlife Manager Jordan Likes jordan.likes@state.co.us at (303) 291-7227 or Serena Rocksund serena.rocksund@state.co.us at (303) 291-7132.

Sincerely,

Matt Martinez
Area Wildlife Manager

Cc: M. Leslie, K. Cannon, J. Likes, S. Rocksund

Responses to Comments from CPW

Borrowing Owls

If applicable, Pioneer will conduct borrowing owl surveys along the Pioneer Water Pipeline route per CPW protocol in areas where prairie dog towns are present within 150 feet of areas planned for disturbance. If burrowing owls are found to be nesting during surveys, Pioneer will adhere to 150-foot buffers from March 15 through October 31.

Natural Vegetation, Wetlands, and Water Sources

Pioneer will restore disturbed construction areas to prior conditions as required by permits and landowner agreements and will follow CPW recommendations to the extent practicable.

Heavy equipment and personal tools previously used near other water sources will be cleaned prior to use for construction activities to prevent the spread of invasive species.

Bald Eagles

Pioneer will adhere to the Recommended Buffer Zones and Seasonal Restriction Guidelines for active Bald Eagle Nests.

4. Colorado Department of Public Health and Environment

Greg Barnes

From:	Hackett - CDPHE, Sean <sean.hackett@state.co.us>
Sent:	Thursday, March 26, 2020 9:09 AM
To:	Greg Barnes
Cc:	Layla Bajelan
Subject:	Re: Request for Comments: RCU2020-00004- Pioneer Produced Water Pipeline CUP
Attachments:	APEN 223 (1).PDF

Please be cautious: This email was sent from outside Adams County

Good morning, Greg;

The Colorado Department of Public Health and Environment (CDPHE) appreciates the opportunity to comment on this proposal. Please note that the following requirements and recommendations are not intended to be an exhaustive list and it is ultimately the responsibility of the applicant to comply with all applicable rules and regulations. Please also note that CDPHE's failure to respond to any referrals should not be construed as a favorable response.

Hazardous and Solid Waste

The applicant must comply with all applicable solid and hazardous waste rules and regulations.

Solid waste regulations are available here:
https://www.colorado.gov/pacific/cdphe/swregs.

Hazardous waste regulations are available here: https://www.colorado.gov/pacific/cdphe/hwregs.

Applicable requirements may include, but are not limited to, testing for and properly disposing of technologically enhanced naturally occurring radioactive materials (TENORM) and other solid or hazardous waste.

If you have any questions regarding solid and hazardous waste, please contact CDPHE's Hazardous Materials and Waste Management Division (HMWMD) by emailing comments.hmwmd@state.co.us or calling 303-692-3320.

Water Quality

The applicant must comply with all applicable water quality rules and regulations. Water quality regulations are available here: https://www.colorado.gov/pacific/cdphe/water-quality-control-commission-regulations.

Applicable requirements may include, but are not limited to obtaining a stormwater discharge permit if construction activities disturb one acre or more of land or if they are part of a larger common plan of development that will disturb one or more acres of land. In determining the area of construction disturbance, CDPHE's Water Quality Control Division (WQCD) looks at the entire plan, including disturbances associated with utilities, pipelines or roads constructed to serve the facility.

Please use the Colorado Environmental Online Services (CEOS) to apply for new construction stormwater discharge permits, modify or terminate existing permits and change permit contacts.

For CEOS support please see the division website: https://www.colorado.gov/pacific/cdphe/cor400000-stormwater-discharge
or contact:

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Email: cdphe_ceos_support@state.co.us or cdphe_wqcd_permits@state.co.us
CEOS Phone: 303-691-7919
Permits Phone: 303-692-3517

WQCD has compliance assistance and guidance materials on their website. There is an Oil and Gas field wide permit guidance that is specifically for construction activities associated with oil and gas. This guidance can be found at https://environmentalrecords.colorado.gov/HPRMWebDrawer/RecordView/1338365.

Additionally, through the Federal Energy Regulatory Commission (FERC) there is a federal requirement for pipeline construction to identify wellhead protection/source water protection areas. The WQCD typically gets a request for this data primarily from the permittee or planning departments (occasionally) and they are happy to provide that information related to drinking water protection areas. WQCD would simply need a shapefile of the proposed area and they could send a list of any potential impacted public water systems.

If you have any questions regarding water quality, please contact CDPHE's WQCD by emailing cdphe.commentswqcd@state.co.us or calling 303-692-3500.

Air Quality

The applicant must comply with all relevant state and federal air quality rules and regulations. Air quality regulations are available here: https://www.colorado.gov/pacific/cdphe/aqcc-regs.

Applicable requirements may include, but are not limited to, reporting emissions to the Air Pollution Control Division (APCD) by completing an Air Pollutant Emissions Notice (APEN). An APEN is a two in one form for reporting air emissions and to obtain an air permit, if a permit will be required. While only businesses that exceed the Air Quality Control Commission (AQCC) reporting thresholds are required to report their emissions, all businesses - regardless of emission amount - must always comply with applicable AQCC regulations.

For this project, a Land Development APEN (Form APCD-223; attached) may be required. Under Colorado air quality regulations, land development refers to all land clearing activities, including but not limited to land preparation such as excavating or grading, for residential, commercial or industrial development. Land development activities release fugitive dust, a pollutant regulation by the Division. Small land development activities are not subject to the same reporting and permitting requirements as large land activities. Specifically, land development activities that are less than 25 contiguous acres and less than 6 months in duration do not need to report air emissions to APCD.

Information on oil and gas APENS and permits can be found at https://www.colorado.gov/pacific/cdphe/air/oil-and-gas-air-permit. In addition to an index of oil and gas forms, guidance, APENs and memos, this website contains an Oil and Gas Industry Emissions Calculation and Regulatory Analysis Workbook to assist operators applying for permits in following approved emissions calculation methods. If you have any questions regarding Colorado's APEN or air permitting requirements or are unsure whether your business operations emit air pollutants, please call the Small Business Assistance Program (SBAP) at 303- 692-3175 or 303-692-3148.

Polyfluoroalkyl substances in firefighting foams

PFAS are a family of human-made substances that do not occur naturally in the environment. They have been used for decades in food packaging, carpets, personal care items, ski waxes, other household items, and firefighting foam due to their ability to resist heat, oil, stains, grease, and water. Human contact with these chemicals is widespread, and nearly all people have some measurable levels of the chemicals in their blood. Human health toxicity information is only available for about ten of the thousands of these chemicals. However, despite the limited information, this toxicity information suggests that exposure to some PFAS can cause a range of negative health outcomes. Health effects from these chemicals may include pregnancy complications, liver damage, high cholesterol, and others. More research is underway to better understand these health consequences. When PFAS is released into the environment, it can get into water, especially groundwater, and contaminate drinking water supplies. Pursuant to House Bill 19-1279, firefighting foam manufacturers will

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be prohibited from knowingly selling or distributing firefighting foam to which PFAS chemicals have been added.

Due to the potential for contamination from the use of fluorine free firefighting foams, the applicant should coordinate with local fire departments to evaluate whether PFAS-free foam can provide the required performance for the specific hazard. If PFAS-containing foam is used at this location, then the applicant should be required to properly characterize any waste that leaves secondary containment, vacuum/drum up any contaminated soil and properly dispose of it in accordance with solid and hazardous waste regulations. If any PFAS-containing foam leaves secondary containment, the applicant should be required to conduct appropriate soil sampling and water quality monitoring.

Health Equity and Environmental Justice

CDPHE is dedicated to promoting and protecting the health and environment for all Coloradans. As part of those efforts, we strive to achieve health equity and environmental justice.

HEALTH EQUITY is when all people, regardless of who they are or what they believe, have the opportunity to attain their full health potential. Achieving health equity requires valuing all people equally with focused and ongoing efforts to address inequalities.

ENVIRONMENTAL JUSTICE is the fair treatment and meaningful involvement of all people regardless of race, color, national origin or income. With respect to the development, implementation and enforcement of environmental laws, regulations and policies.

CDPHE notes that certain projects have potential to impact vulnerable minority and low-income communities. It is our strong recommendation that your organization consider the potential for disproportionate environmental and health impacts on specific communities within the project scope and if so, take action to mitigate and minimize those impacts. This includes interfacing directly with the communities in the project area to better understand community perspectives on the project and receive feedback on how it may impact them during development and construction as well as after completion. We have included some general resources for your reference.

Resources:
CDPHE's Health Equity Resources
CDPHE's Checking Assumptions to Advance Equity
EPA's Environmental Justice and NEPA Resources

Best,

Sean Hackett
Energy Liaison
4300 Cherry Creek Drive South, Denver, CO 80246
Office Phone 303.692.3662 | Cell Phone 303.587.1423
sean.hackett@state.co.us | www.colorado.gov/cdphe
Your feedback is important to us! Please let us know how I am doing.

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Responses to Comments from CDPHE

Hazardous and Solid Waste

Pioneer will comply with applicable CDPHE solid and hazardous waste rules and regulations during construction of the Pioneer Water Pipeline.

Water Quality

Pioneer will comply with applicable CDPHE water quality rules and regulations during construction of the Pioneer Water Pipeline.

Air Quality

Pioneer will comply with relevant CDPHE state and federal air quality rules and regulations and will submit a Land Development APEN if required.

Polyfluoroalkyl Substances in Firefighting Foams

Pioneer does not propose to use firefighting foam as part of this Pioneer Water Pipeline.

Health Equity and Environmental Justice

Pioneer will consider the potential for disproportional environmental and health impacts on specific communities and mitigate and minimize disproportionate environmental land health impacts where practicable.

APEN

Pioneer will provide documentation that a Construction Permit has been obtained if necessary and will provide documentation of APEN submittal to CDPHE prior to construction.

5. City of Thornton

City of Thornton

City Hall
9500 Civic Center Drive
Thornton, Colorado 80229-4326

City Development Department
303-538-7295
FAX 303-538-7373
www.thorntonco.gov

March 27, 2020

Greg Barnes
Case Manager
4430 South Adams County Pkwy Ste. W2000A
Brighton, CO 80601

RE: Pioneer Produced Water Pipeline CUP – RCU2020-00004 – CUP

Mr. Barnes:

The City of Thornton has the following comments regarding the Pioneer Produced Water Pipeline Conditional Use Permit.

Based on the response to the comments below, the City of Thornton requests to be included in future resubmittal reviews of this project.

Infrastructure Engineering
Darwin Williams, Civil Engineer (darwin.williams@thorntonco.gov)

The City of Thornton is currently designing a 42" fully welded steel raw water pipeline along Quebec Street. The design will align the pipeline as follows:

- For the north half of the segment (160th Avenue to 168th Avenue), the pipeline will assume an existing easement on the east side of Quebec Street.
- For the south half of the segment (160th Avenue to 168th Avenue), the pipeline will align on the west side of Quebec Street, in the existing right-of-way.

As this is a future source of drinking water for the City, it is suggested that the applicant be aware of its future design and to eliminate any conflicts during their design.

Infrastructure Engineering
Rachelle Plas, Civil Engineer (rachelle.plas@thorntonco.gov)

Any work that is proposed within Thornton's jurisdiction in a FEMA floodplain or other Special Flood Hazard Area, will need a Floodplain Development Permit from Thornton.

Development Engineering
Cassie Free, Development Engineering Manager (cassie.free@thorntonco.gov)

It is unclear where the alignment of the pipeline is in the current application. Additionally, the right-of-way crossing at Quebec Street is City of Thornton right-of-way, and would require permitting through the Infrastructure Department.

Development Engineering
Heather Croke, Civil Engineering Technician I (heather.croke@thorntonco.gov)

- The City highly recommends getting title work to obtain information for easements, adjacent properties, etc.
- The waterline is required to remain outside of the city's easements and property.
- The waterline is required to remain outside future right-of-way for Highway 7, 152nd Avenue, Holly Street, Quebec Street and 156th Avenue.
- All utility crossings should be at 90 degrees and have City of Thornton approval.

End of Comments

Please contact me at 303-538-7301, or via e-mail at Sadie.Naglich@thorntonco.gov for updates and/or questions related to this response.

Sincerely,

Sadie Naglich
Planner I

cc: Greg Barnes, GJBarnes@adcogov.org
Cassie Free, Development Engineering Manager
Heather Croke, Civil Engineering Technician I
Darwin Williams, Civil Engineer
Rachelle Plas, Civil Engineer

V:\PLANNING DIVISION\Outside Referrals\Adams County\Adams County 2020\Adams County Pioneer Produced Water Pipeline CUP PLOSR202000460

Responses to Comments from the City of Thornton

Pioneer requests that Adams County provide the following responses to comments to the City of Thornton. Pioneer has been in contact with Colin Wahab, Senior Planner with the City of Thornton, to discuss permitting requirements within the City of Thornton Jurisdiction.

Infrastructure Engineering—Darwin Williams

Pioneer has incorporated the design and alignment of the City of Thornton's 42-inch raw water pipeline into the design and alignment of the Pioneer Water Pipeline along Quebec Street between 160th and 168th. No conflicts are expected.

Infrastructure Engineering—Rachel Plas

Pioneer will apply for a Floodplain Development Permit from the City of Thornton if work within a FEMA floodplain or other Special Hazard Area is Required.

Development Engineering—Cassie Free

Pioneer will ensure that the applicable permits for ROW crossings within the City of Thornton's jurisdiction have been approved by the Infrastructure Department prior to construction.

Development Engineering—Heather Croke

Prior to construction within Adams County, easements for parcels within Adams County will be provided prior to construction. Pioneer understands that the waterline is to remain outside the City of Thornton's future ROWs for Highway 7, 152nd Avenue, Holly Street, Quebec Street, and 156th Avenue. Pioneer understands that all utility crossings occur at near 90-degree angles when possible and be constructed following the City of Thornton's approval.

Greg Barnes

From: Peggy Davenport <pdavenp@e-470.com>
Sent: Tuesday, May 26, 2020 2:17 PM
To: Greg Barnes
Subject: RCU2020-00004 Pioneer Water Pipeline resubmittal DUE 05.21.20 gjbarnes

Thank you for allowing the E-470 Public Highway Authority the opportunity to review and respond to RCU2020-00004 Pioneer Water Pipeline resubmittal DUE 05.21.20 gjbarnes.

At this time E-470 Public Highway Authority has the following comments:

- Occupying space for utility work, access, and any construction within the E-470 ROW and MUE (multi-use easement) is subject to and will be in compliance with the E-470 Public Highway Authority Permit Manual, April 2008, as may be amended from time to time (the "Permit Manual") and will require an E-470 Construction or Access Permit. The administration fee is $750.00 and $75,000 per acre for construction.
- A permit will be required from E-470 for any encroachment or disturbance to E-470 ROW or MUE prior to construction.
- Here is a link to our permit: https://www.e-470.com/Pages/WorkingWithUs/Permits.aspx
- The applicant must secure all approvals/agreements from the proper jurisdictions/entities within the E-470 corridor.
- Clearly label the ROW and MUE on all applicable drawings.
- Clearly show the TBMS (fiber) in both the plan and profile drawings.
- We prefer the proposed waterline be located 5' from the existing Discovery pipeline when in E-470 ROW/MUE.
- Areas of ATWS need to ensure they are outside the clear zone or provide adequate safety/protection to both the traveling public and materials/equipment stored.
- A dig watch will need to be scheduled when crossing the TBMS line.
- E-470 will be widened in the future to 4 lanes each direction. Please confirm a minimum cover of 5' will be provided when the highway is widened.
- All disturbed areas shall be reseeded with E-470 approved seed mix unless otherwise noted.
- All ROW fence disturbed will be reset and/or replaced if disturbed.
- Any survey markers disturbed or destroyed will need to be replaced.
- Proposed utility crossings of E-470 will be required to be bored across the highway from ROW to ROW unless otherwise agreed upon.
- Provide a limits of construction for both trenching and the bore pit in both the plan and profile.
- Pavement and utility deflection monitoring will be required for the bore across E-470.
- No construction access from E-470 will be allowed.
- Additional comments will be issued as design progresses.

For any question concerning the comments listed below please contact Chuck Weiss at 303.537.3420 or cweiss@E-470.com.

Please advise if we can be of further assistance.

Peggy Davenport
Administrative Assistant/Document Control
E-470 Public Highway Authority
22470 E Stephen D Hogan Parkway
O: 303.537.3727
C: 720-765-1276
pdavenport@E-470.com
Please note: I am working remotely 6:00am – 2:30pm M-F. Please allow additional time for responses and contact my mobile if you need to speak to me directly.

7. Metro Wastewater Reclamation District

Greg Barnes

From: Owens, David <Dowens@mwrd.dst.co.us>
Sent: Wednesday, March 18, 2020 1:03 PM
To: Greg Barnes
Subject: RE: RCU2020-00004 Pioneer Produced Water Pipeline CUP
Attachments: SP drawings for RCU2020-00004.pdf

Please be cautious: This email was sent from outside Adams County

Greg,

I am attaching the plan/profile drawings for our South Platte Interceptor for the developer's use in design for the above referenced project. It appears that the area shown on the attached plans is where a proposed crossing for the produced water line is.

Let me know if you have any questions.

David Owens
Engineering Tech II
Metro Wastewater Reclamation District
6450 York Street
Denver, Colorado 80229
(303)286-3397

From: Greg Barnes [mailto:GJBarnes@adcogov.org]
Sent: Monday, March 16, 2020 12:37 PM
To: Owens, David <Dowens@mwrd.dst.co.us>
Subject: RE: RCU2020-00004 Pioneer Produced Water Pipeline CUP

Hello,

In the letter, I mentioned that all information and color maps can be found at this link:
http://www.adcogov.org/planning/currentcases

Please let me know if you have any further questions.

From: Owens, David <Dowens@mwrd.dst.co.us>
Sent: Friday, March 13, 2020 2:53 PM
To: Greg Barnes <GJBarnes@adcogov.org>
Subject: RCU2020-00004 Pioneer Produced Water Pipeline CUP

Please be cautious: This email was sent from outside Adams County

Mr. Barnes,

Regarding the above referenced project, any utility lines that are proposed to be installed across Metro Wastewater's sanitary sewer interceptors will need to have the plans reviewed and approved by Metro staff. Please forward any more

1

detailed drawings, when available for this project, should any Metro Wastewater infrastructure be proposed to be impacted by the construction of this project for review.

Please let me know if you have any questions of me on this.

David Owens
Engineering Tech II
Metro Wastewater Reclamation District
6450 York Street
Denver, Colorado 80229
(303)286-3397

2

Response to Comments from the Metro Wastewater Reclamation District

Pioneer will incorporate Metro Wastewater Reclamation District's South Platte Interceptor into the pipeline design. At this time, no intersections between Metro Wastewater Reclamation District's South Platte Interceptor and the Pioneer Water Pipeline are anticipated.

8. United Power

Greg Barnes

From: United Power Plat Referral <platreferral@UnitedPower.com>
Sent: Monday, March 23, 2020 4:30 PM
To: Greg Barnes
Subject: FW: Request for Comments: RCU2020-00004- Pioneer Produced Water Pipeline CUP
Attachments: Request for Comments RCU2020-00004 Pioneer Produced Water Pipeline.pdf

Please be cautious: This email was sent from outside Adams County

Hello,

Thank you for inviting United Power, Inc. to review and comment on the RCU2020-00004- Pioneer Produced Water Pipeline CUP. Being that this project is so large, please have the developer/contractor contact work closely with United Power on a case-by-case bases as they encounter any easements/ROW with our equipment within it.

Thank you,

Samantha

Right of Way Administrative Assistant
303-637-1324
UNITEDPOWER
500 Cooperative Way | Brighton, CO 80603
Powering Lives, Powering Change, Powering the Future - The Cooperative Way
www.unitedpower.com

From: Layla Bajelan <LBajelan@adcogov.org>
Sent: Wednesday, March 4, 2020 7:27 PM
To: Layla Bajelan <LBajelan@adcogov.org>
Cc: Greg Barnes <GJBarnes@adcogov.org>
Subject: Request for Comments: RCU2020-00004- Pioneer Produced Water Pipeline CUP

CAUTION: This email originated from outside of United Power. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Request for Comments

Case Name: Pioneer Produced Water Pipeline CUP
Case Number: RCU2020-00004

Response to Comments from United Power

Pioneer will coordinate with United Power, Inc. on a case-by-case basis if any easements/ROW with United Power equipment are encountered along the Pioneer Water Pipeline route.

9. Public Service Company of Colorado

Xcel Energy℠
PUBLIC SERVICE COMPANY

Right of Way & Permits

1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571.3284
donna.l.george@xcelenergy.com

March 30, 2020

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Layla Bajelan

Re: Pioneer Produced Water Pipeline, Case # RCU2020-00004

Public Service Company of Colorado's (PSCo) Right of Way and Permits Referral Desk has determined there are **possible conflicts** with the above captioned project. Public Service Company has an existing *electric* **transmission** line at 160th Avenue and Riverdale and an existing *high pressure natural gas* **transmission** pipeline at 160th Avenue and Yosemite crossing the proposed pipeline. Any activity including grading, proposed landscaping, erosion control or similar activities involving our existing right-of-way will require Public Service Company approval. Encroachments across Public Service Company's easements must be reviewed for safety standards, operational and maintenance clearances, liability issues, and acknowledged with a Public Service Company License Agreement to be executed with the property owner. PSCo is requesting that, prior to any final approval of the development plan, it is the responsibility of the property owner/developer/contractor to contact the following for development plan review and execution of License Agreements:

- **for Electric Transmission**: email coloradorightofway@xcelenergy.com or website www.xcelenergy.com/rightofway
- **for High Pressure Natural Gas Transmission**: https://www.xcelenergy.com/working_with_us/builders/encroachment_requests - click on Colorado if necessary; an engineer will then be in contact to request specific plan sheets

PSCo also has *natural gas* **distribution** facilities throughout the proposed pipeline project. As always, PSCo would like to remind the developer to call the Utility Notification Center by dialing 811 to have all utilities located prior to any construction. Proper clearances must be maintained including ground cover shall not be modified from original depths. When excavating within 18" (24" is preferred) of marked facilities, hand digging strongly recommended. Please be aware that all risk and responsibility for this request are unilaterally that of the Applicant/Requestor.

Should the project require any modification to existing **distribution** facilities, the property owner/developer/contractor must complete the application process via xcelenergy.com/InstallAndConnect.

Donna George
Right of Way and Permits
Public Service Company of Colorado / Xcel Energy
Office: 303-571-3306 – Email: donna.l.george@xcelenergy.com

Exhibit B

Minimum Requirements for Grading and Excavation near Public Service Company of Colorado Transmission Pipeline(s)

1) General

a. Colorado State Law Requires notification before excavation around utilities occurs. Requestor or Requestor's Contractor must call the Utility Notification Center of Colorado (UNCC) 1-800-922-1987 (811 when calling within Colorado) 48 hours prior to excavation, including the grading of the right of way, begins. Public Service Company of Colorado (PSCo) representatives provide these construction locates at its' cost as a participant in the one call system.

b. All costs for labor, equipment and materials required to repair any damage to the pipeline(s) caused by Requestor or its' Contractors will be the responsibility of the Requestor and/or its Contractors for reimbursement to PSCo.

c. Requestor's Contractor shall provide access to PSCo facilities on the project site for inspection by PSCo Personnel. Open excavations that need to be entered by PSCo Personnel shall conform to all federal, state and local jurisdictional codes and regulations governing safe entry and exit from open excavations.

d. A fully executed agreement, applicable to the type of right being requested, between the Requestor and PSCo must be completed prior to construction activity within the PSCo ROW.

e. Requests for installation of improvements by Requestor within the PSCo ROW must be reviewed and approved by PSCo High Pressure (HP) Gas Engineering and Operations. Installation of, and all costs associated with any improvements, are the responsibility of the Requestor. All costs associated with repairs or relocation of these improvements to accommodate PSCo Operations and Maintenance work on the existing pipeline(s) or installation of a new pipeline will be the responsibility of the Owner of record of the property at the time the work is performed.

f. In the mutual interest of project coordination and scheduling of PSCo resources for your project, PSCo requests invitation to the Pre-Construction Meeting to obtain actual schedules and construction plans, make introductions and address any site specific conditions or project changes that have occurred between Final Design Review and Construction.

g. Any exceptions to the Minimum Requirements stated in this document must be requested in writing and reviewed by PSCo HP Gas Engineering and Operations before approval for construction activity on the PSCo pipeline(s) permitted ROW is given.

h. Any change in Requestor's construction plan and or scope of work that was agreed to between the Requestor and PSCo prior to, or during, construction must be presented to PSCo HP Gas Engineering and Operations for additional review and modification of requirements.

i. Additional requirements may apply to address issues not foreseen during review of Requestor's proposal.

2) **Engineering**

a. Specifications of weight and type of any heavy equipment or trucks planned to be run over or along the pipeline(s) are required to be submitted to PSCo HP Gas Engineering for analysis of excessive live load stresses induced on the pipeline(s) prior to approval for crossing is given.

   i. Should calculated allowable stresses induced by Requestor equipment traveling over the PSCo pipeline(s) be exceeded, Requestor will be required to install additional temporary fill over the pipeline(s).

   ii. If calculated allowable combined stress on the pipeline(s) can not be reduced below limits by adding additional protective fill over the pipeline(s) or the depth of additional fill is deemed impractical, a temporary bridging structure installed over the pipeline(s) will be required to mitigate the excess stress on the pipeline(s).

      1. This bridging structure must be constructed of timbers, plates or other material that does not allow the driving surface to come in contact with the ground surface. The supports for the driving surface of the bridging structure may be of dirt or other material with the inside edges of the supports placed a minimum of 5 feet from the center line of the PSCo pipeline(s).

b. Requestor's Plans must contain surveyed horizontal location of the PSCo pipeline(s) throughout the project area based on current field locates. Surveyed vertical location of the PSCo pipeline(s) based on pothole information must be presented on the Proposed Construction Drawings Profile Sheets at all Requestor facility crossing locations of the pipeline(s) prior to final comment and approval of the plans.

c. Locates and or potholing for the purpose of Requestor's engineering, design and construction drawings to establish the horizontal and vertical locations of PSCo facilities and all associated costs will be the responsibility of Requestor. A PSCo representative will be required to be on site during any pothole operations.

   i. Potholing with excavation equipment during frost conditions will not be allowed unless contractor thaws ground prior to excavation. Potholing with vac-truck will be allowed under any conditions

d. **Any excavator acting in a reckless manner while working in the area of Xcel Energy pipelines shall be asked to stop their work in that area. Work will not be allowed to continue until Xcel Energy personnel deem the situation has returned to a safe situation.**

e. Blasting Near PSCo Facilities

i. Notification

1. In accordance with Article 7 of Title 9 of CRS "Explosive Act", Section 6.1.7, Utilities must be notified at least 24 hours prior to commencement of blasting activity. If Blasting is anticipated for this project an "Explosive Use Application and Notification" and the associated Agreement Document must be processed before blasting activities may commence near the PSCo pipeline(s). It is recommended that this notification be made at least one month in advance of actual blasting activities to allow for processing of these documents and any studies that may need to be performed to access the applicants blasting plan.

ii. Limits

1. Buried Pipe - Total Combined (Effective) Stresses on the pipe must not exceed 50% of the specified minimum yield strength of the pipe.

2. Above Ground Pipe –Blasting operations must not generate Peak Particle Velocity (PPV) greater than 1 in/sec.

f. Vibrations from dynamic compaction equipment or other sources must be maintained at a peak particle velocity of not greater than 1 in /sec as measured in any one of the three components of a seismographic reading.

3) **Inspection**

a. PSCo will require that one of its Field Operators be on site during the potholing, excavation, site grading, backfill operations, compaction, and installation of your facilities when working within the pipeline(s) easement and/or a minimum of fifteen (15) Ft from the outer limits of the locate marks for the PSCo pipeline(s). This standby expense is covered by PSCo during a normal 8 hour day Monday - Friday. Any time required in excess of 8 hours per day or weekend and holidays will be billed to the Third Party of the facilities under construction at the applicable PSCo Labor Overtime Rates and Equipment/Vehicle Rates.

b. Requests for standby will be filled on a first-come, first-served basis, consistent with the number of personnel available for standby and Xcel Energy workload at that time. It is not our intent to unnecessarily impede the work schedule of the installation contractor, and we will strive to be as available as possible.

c. Appointments for standby excavations shall be scheduled to minimize the amount of time Xcel Energy personnel are waiting during contractor setup. Contractors will be charged at the applicable straight time or overtime PSCo labor rate and Equipment/Vehicle per hour for time between appointment time and actual start time (i.e. a call for an 8:00 A.M. standby and actual construction start time of 10:00 A.M. will result in 2 hours of the applicable straight time or overtime PSCo labor and Equipment/vehicle charges)

d. Frequency and duration of Field Operator Standby will be determined during the initial site visit with the Requestor's Construction Contractor based on construction schedule and phasing of construction activities as they relate to work near the PSCo pipeline(s).

e. Potholing frequency during construction will be at the discretion of the PSCo Inspector on site on an as needed basis based on field conditions and proximity of the excavation to the pipe.

f. Potholing with excavation equipment during frost conditions will not be allowed unless contractor thaws ground prior to excavation. Potholing with vac-truck will be allowed under any conditions.

4) Construction

a. Grading, Excavation, Installation, Backfill

i. A "Method of Construction Plan" shall be provided to PSCo HP Gas Engineering and Operations for review and approval prior to the beginning of construction.

ii. For Parallel Encroachments, the recommended method of construction is to place the trench spoils between the Requestor line and the PSCo line and set the working side on the opposite side of the trench from the spoil pile.

1. Alternate Method of Construction
   a. Install a layer of straw or some other method of identifying the top of the existing ground elevation then place trench spoils on top of the line. During backfill operations, removal of the spoil shall stop at the level of the warning material.

   b. Requests to work above existing PSCo pipeline(s), either on top of existing ground elevation or top of spoil pile, will be reviewed on a case by case basis. Requestor must provide specs for all equipment that will be traveling on top of the line for calculation of combined stresses for determination if allowable combined stress levels are exceeded prior to approval of this method

iii. The maximum unsupported length of PSCo's 2" and larger diameter High Pressure Natural Gas pipeline(s) is 15 feet.

1. Specific calculations can be made for pipe diameter's greater than 2" in outside diameter to determine greater free span lengths.

2. Should Requestor excavation require a greater length of the pipe be exposed than allowable stress limits dictate, plans for providing support will be required to be submitted to PSCo HP Gas Engineering for review and approval. This support system can be provided by the third party's contractor and installed under the supervision of the on-site PSCo Energy Employee. A list of qualified pipeline contractors to perform this work, if needed, can be supplied to you if so requested.

iv. If site re-grading leaves less than 36" of cover over the PSCo pipeline(s), the pipe will have to be lowered or additional protection measures installed over the pipe such as concrete capping or steel plating. Any mitigation measures, including engineering of such structures, will be at the expense of the Third Party of the facilities being constructed.

v. Backfill operations around exposed sections of PSCo's pipeline(s) shall be inspected by a PSCo representative.

vi. Any sections of the PSCo pipeline(s) that are exposed during construction must be padded with material passing ¾" minus screens that is non-angular in shape to a depth of one (1) foot above the top of pipe before native material passing 6" minus screens or two (2) feet above the top of pipe before native material passing greater than 6" plus screens can be used for the remaining backfill. Bedding material of an angular nature and/or passing 2" minus screens may be used if rock shield, epoxy coating applied to a thickness of 30 mils or greater, or other abrasion resistant coating, is installed around the pipe over the entire exposed length. Installation of any such additional protective coating installation shall be inspected by a PSCo representative.

vii. Utilization of flowable fill with cement or fly ash binder material may be utilized once one (1) foot of cover is established over the PSCo pipeline(s) with consolidated, non-abrasive, bedding material. The flowable fill must be able to be excavated with a shovel. The flowable fill shall extend ten feet on either side of the PSCo pipe and extend to the trench walls. The use of flowable fills is subject to approval of the local government authorities.

viii. Other backfill material not requiring additional compactive effort to obtain required dry densities of the project specifications may be utilized around the pipe. Submittal of a backfill plan and material specifications shall be presented to PSCo HP Gas Engineering and local government authorities for review before approval is granted.

ix. Permanently added fill over PSCo pipeline(s) shall not exceed a typical depth of cover of four (4) feet over the top of PSCo's pipeline(s) at final grade. Exceptions due to terrain, grading requirements and re-establishment of slopes must be reviewed with PSCo HP Gas Engineering but shall not exceed eight (8) feet of cover over the top of the PSCo pipeline(s).

b. Compaction over PSCo Pipelines

i. No heavy vibratory compaction equipment (driver operated) will be allowed over or along the length of the PSCo pipeline(s) in the area requiring compaction and for a distance of ten (10) feet on either side of the outside wall of the pipe and ten (10) feet from the ends of the pipe length at the compaction area limits if less than three (3) feet of cover is left over the pipe after sub excavation work is completed.

ii. Light vibratory compaction equipment (jumping jacks, walk behind or remote control rollers) may be utilized once the minimum one (1) foot of bedding material cover over the top of the PSCo pipeline(s) is established.

c. Facility Crossings

i. Buried Facility Crossings of the PSCo pipeline(s) will be required to go under or over the PSCo pipeline(s) with a minimum clearance of two (2) feet to the bottom or top respectively of the PSCo pipeline(s).

ii. Buried facilities installed parallel to the PSCo pipeline(s) must maintain a minimum horizontal separation of ten (10) feet from the pipeline(s). If this minimum horizontal separation cannot be maintained, the top of the facility being installed will be required to be one (1) feet below the bottom of the PSCo pipeline(s) for every foot closer than ten (10) feet to the pipeline(s).

d. Improvements/Structure/Facility Placement

i. No surface or sub-grade structures or utility facilities will be allowed within the PSCo ROW limits without plan review approval from PSCo HP Gas Engineering and Operations. Potential ignition source facilities shall be a minimum of fifteen (15) from the outside wall of the pipe

e. Landscape Installation

i. No planting of vegetation will be allowed within the PSCo ROW limits without plan review approval from PSCo HP Gas Engineering and Operations. Under no circumstances will trees be allowed to be planted over the pipeline(s) within the PSCo ROW limits and shall be no closer than fifteen (15) feet from the outside wall of the pipe.

f. Cathodic Protection

i. A copy of the Requestor Cathodic Protection (CP) System design shall be provided to PSCo for review prior to construction. .

ii. At crossing locations, Stray Current Mitigation will be required if either pipeline is cathodically protected from a rectified ground bed system. At a minimum this shall consist of a run of two # 8 wires from Public Service Company (PSCo) pipe and 2 # 8 wires up from the third party facility pipe into a common or separate test station for bonding of the two systems together if necessary. The wires could either run to the test station in a common conduit or separate conduits. In addition, four 17# or larger anodes are to be placed in each quadrant of the crossing pipes and placed vertically equidistant between the two pipelines. PSCo will provide the material for its CP test station and assist **Requestor's** contractor with installation of the test station.

iii. For parallel encroachments, at locations where third party is installing a CP Test Station, the third party will be required to expose the PSCo pipeline(s) for installation of a CP test station for monitoring of interference. PSCo will provide the material for its CP test station and assist the third party's contractor with installation of the test station.

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5) **Post Construction**

a. Permanent Private Road Crossings

i. Permanent private access roads intended for use by vehicles with a loaded single axle rating of less than or equal to CDOT load limits, must provide and maintain a minimum of **4** feet of cover over the PSCo pipeline(s). Any party needing to cross the PSCo pipeline(s) with vehicles in excess of the CDOT Load Limits per single axel must contact PSCo for additional requirements or place bridging structures over the located pipeline(s).

ii. Permanent private access roads intended for use by vehicles with a loaded single axle rating of less than or equal to 20,000 lb per axle, must provide and maintain a minimum of **4 (four)** feet of cover over the PSCo pipeline(s).

iii. Tracked equipment crossings of the PSCo pipeline(s) must be made via tractor/lowboy transport adhering to the restrictions of section 5.a.i. and 5.a.ii. If it is desired to track the equipment over the PSCo pipeline(s), PSCo must be contacted to calculate the limits for the specific piece of equipment or provide a bridging structure over the pipeline(s) in accordance with Section 2.a.ii.1.

b. Four wheel all terrain sport and utility vehicles and dirt bikes are exempt from this section's restrictions. A minimum cover of twelve (12") inches of dirt over the pipe must be present before these vehicles can cross over the pipe.
c. It is recommended that Requestor install and maintain load limit signage at all road crossings of the PSCo pipeline(s).
d. PSCo will place pipeline markers at all permanent road crossings that are to remain at the conclusion of the installation of the Requestor pipeline.

Response to Comments from Public Service Company of Colorado

Pioneer will ensure that construction activities that involve Public Service Company of Colorado's existing ROW be approved prior to construction commencement. Pioneer will comply with Public Service Company of Colorado's General, Engineering, Inspection, Construction, and Post Construction standard and requirements for Pioneer Water Pipeline construction occurring near their facilities.

10. B. Michl Lloyd

March 21, 2020

Adams County Community & Economic Development Department, Development Services Division
4430 South Adams County Parkway, 1st Floor, Suite W2000A
Brighton, CO 80601-8218

RE: Comments on Pioneer Produced Water Pipeline Conditional Use Permit RCU2020-00004

Dear Mr. Barnes:

This letter is in response to your request for comments on Pioneer Water Pipeline's application for a conditional use permit. Please be aware that I have granted Pioneer a one year option for a 10 foot easement across the southwest corner of my property in unincorporated Adams County. I have not been informed yet as to whether or not Pioneer plans on exercising such option. Also the map you sent with your request for comments is so condensed I am not able to tell if the corner of my property is in the current plan.

In any case, I am in favor of the pipeline as it was described to me because it will reduce truck traffic and I would think the pipeline would be safer that trucks transporting the water. My neighbor has told me that he has asked project related questions of Tetra Tech representatives and has been satisfied with the answers he has received from them.

I did not attempt to access the full version of Pioneer's application and accordingly, the following two observations/questions about the project may be answered/addressed in that material:

- Pipeline Pressure – Pressures of 240 psi to 300 psi are mentioned in the application. I do not recall the pressure that was mentioned to me when I granted the option for the easement but I do not think that the pressure range was that high. I realize that such pressures may be necessary to overcome elevation changes and distances and I do not have an issue with the stated pressure range as long as it is signed off by Pioneer's engineers and is acceptable to Adams County staff.

- Produced Water Quality – Pioneer conducted a public meeting on the proposed project however I was not able to attend. I was told by a neighbor who did attend that they included a discussion of produced water from the oil/gas wells. The neighbor that attended indicated they acknowledged that the produced water could contain some hazardous chemicals/materials and before it would enter the pipline a very high percentage of such chemicals/materials would be removed and be disposed of as required by environmental regulations. In addition I was told that they stated that no water from other than the approved well sites would be allowed to enter the pipeline (i.e. a well site that was not directly on the pipeline could not transport water to a well site that is on the pipeline and have it enter the pipeline.)

This discussion would lead one to believe that the water in the pipeline would be relatively safe and if a leak did occur that it would require cleanup but would not likely create a hazardous disaster.

Neither of these water quality matters were discussed in Pioneer's written description provided in your request for comments and if they are not addressed in the full version of Pioneer's application I believe the applicant should address these issues to the County Staffs' satisfaction before any permit is granted. Please contact me at 303-659-4545 or via email at bmlloyd@aol.com if you have any questions regarding the above and thank you for the opportunity to comment.

Yours truly,

B. Michl Lloyd

Responses to Comments from B. Michl Lloyd

Pioneer requests that Adams County provides these responses to Mr. B. Michl Lloyd on behalf of Pioneer.

Pipeline Pressure

The pipeline would transport the produced water at a maximum pressure of approximately 240 pounds per square inch (psi) until it reaches a storage tank at EWS #6. The Pioneer Water Pipeline would operate at an estimated 240 psi, but they may operate at a higher pressure depending on temperature. The maximum allowable pressure will be 333 psi. Pioneer would control pressure and monitor temperature using pressure control valves located along the Pioneer Water Pipeline route.

Illustration 1 from the CUP application includes estimated pressures and is included below for ease of reference.

Produced Water Quality

Produced water, also known as wastewater, is recovered as byproduct that is brought to the surface during oil and gas production. Oil, gas, and produced water leaves the well head at pressures up to 3,000 psi. The content of produced water varies with the formation where the water originates, but it is generally high in salts with trace amounts of other minerals.

Pioneer will have an Emergency Response Plan in place prior to the pipeline becoming operational to ensure that in the appropriate emergency responses will occur should a leak occur.

PIONEER WATER PIPELINE DIAGRAM

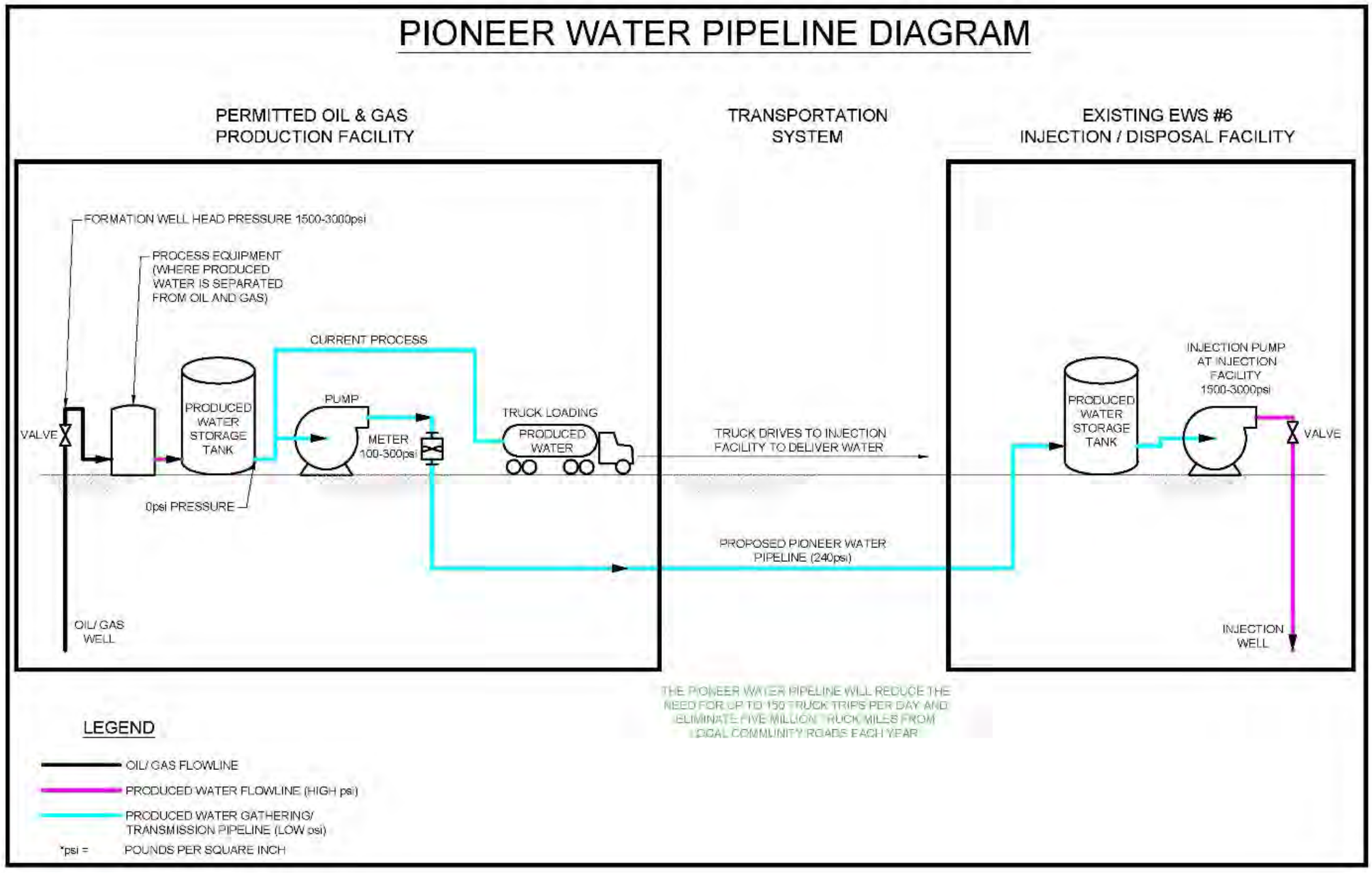
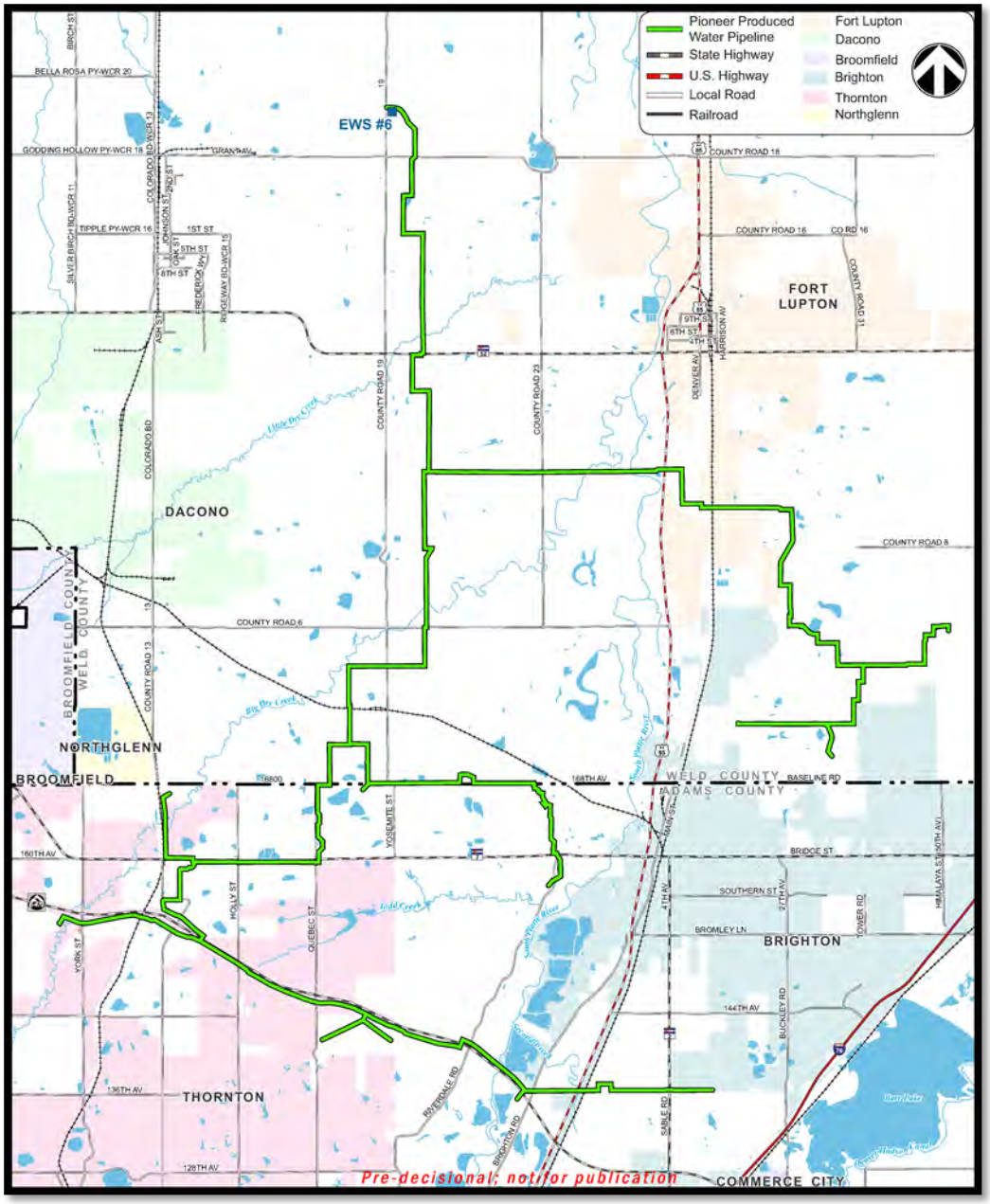


Exhibit G:
Neighborhood Meeting Notification, Meeting Materials, and Summary

Pioneer Water Pipeline Project

Neighborhood Meeting Report
December 10, 2019



Pioneer Water Pipeline Project Overview map showing the preferred pipeline route.

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Appendices

Introduction

Pioneer Water Pipeline, LLC, (Pioneer) operated by Expedition Water Services, LLC, proposes to construct, own, and operate the Pioneer Produced Water Pipeline (Project) within Adams and Weld counties in Colorado. Pioneer held a neighborhood meeting in accordance with Adams County Development Standards and Regulations from 5 p.m. to 8 p.m. on Tuesday, December 10, 2019, at Todd Creek Golf Club (8455 Heritage Dr., Thornton, CO 80602). The purpose of this report is to document the meeting notification and questions asked during the meeting and provide a summary of the meeting results.

Project Overview

The Project would consist of construction of approximately 45 miles of 4- to 12 inch-diameter high-density polyethylene (HDPE) gathering pipelines and associated appurtenances in Adams and Weld counties. Approximately 27 miles of pipeline would be located in Weld County, and 18 miles of pipeline would be located in Adams County. Within Adams and Weld counties, the Project would traverse unincorporated areas and may traverse portions of Brighton, Thornton, and Fort Lupton.

Production water, also known as wastewater, is recovered as byproduct that is brought to the surface during oil and gas production. The Project is designed to transport production water from approximately 22 oil and gas production facilities in Adams and Weld Counties to Expedition's existing EWS #6 wastewater injection and disposal facility in Weld County.

Construction of the pipelines would require an approximately 10-foot-wide permanent easement plus an additional 30-foot-wide temporary workspace. Additional temporary workspaces would also be required at locations where the pipelines cross roads or other existing infrastructure, for example, or where environmental features such as wetlands and waterbodies are present. Appurtenant aboveground facilities such as isolation valves, pumps and inline inspection tool launcher, and receivers would be located at the existing oil and gas well pad sites, and other appurtenant facilities would be located along pipelines within the 10-foot-wide permeant pipeline easements.

Neighborhood Meeting Summary

The Project Neighborhood Meeting was held from 5 p.m. to 8 p.m. on Tuesday, December 10, 2019, at Todd Creek Golf Club (8455 Heritage Dr., Thornton, CO 80602) in the City of Thornton.

The purpose of the Project Neighborhood Meeting was to provide the community a description of the Project and answer related questions from the attendees. The event was conducted in an open house format, which allowed for attendees to arrive at their convenience during a three-hour timeframe. At the meeting, attendees had an opportunity to obtain Project information based on specific areas of interest, speak directly with Project staff, and provide written and verbal comments regarding the Project.

Reproductions of the display boards, maps, contact cards, flyer, and Project information sheet used at the Neighborhood Meeting are included in Appendix A.

Neighborhood Meeting Notification

Pioneer used a direct-mail notification (Appendix B) to inform the Project stakeholders of the Project Neighborhood Meeting based on a mailing list provided by Adams County for the Project on October 11, 2019 (Appendix C). The list included four neighborhood organizations: Riverside Village Owners Association, Todd Creek Village Park and Recreation District, Todd Creek Meadow Owners Association, Inc., and Todd Creek Village Metropolitan District. A total of 389 notifications were sent. A map of the notification area is included as Appendix D. An affidavit of mailing is included as Appendix E.

The notification letter contained the following information: purpose, date, time and place of the meeting; Project location map; and Project contact information. This notification was sent by the U.S. Postal Service presorted marketing mail on Nov. 27, 2019. The timing of the distribution of the notification letter complied with Adams County Standards and Regulations as the notification letters were sent out 13 days prior to the Project Neighborhood Meeting.

Attendance and Comments Analysis

Nine members of the public signed into the Project Neighborhood Meeting. Adams County staff were notified of the Project Neighborhood Meeting date, time, and location and were invited to participate in the Project Neighborhood Meeting. Copies of the sign-in sheets are included in Appendix F.

Six Project team members attended the open house in addition to the members of the public. Team members are listed below in Table 1. A Spanish interpreter was also in attendance.

Table 1:
Project Team Members at Neighborhood Meeting

Name	Organization	Name	Organization
John Heule	Tetra Tech CES	Jim Goddard	Pioneer Water Pipeline, LLC
Max Pivonka	Tetra Tech CES	Deana Perlmutter	Forbes Tate Partners
Zach Neal	Pioneer Water Pipeline, LLC	Taylor Christy	The Integral Group
Spence McCallie	Pioneer Water Pipeline, LLC		

Comment Cards

Comment cards were provided to attendees at the Project Neighborhood Meeting. A blank comment form is provided in Appendix A. Stakeholders had the opportunity to submit written comments via the Project email address or by mailing comment cards to Pioneer. Commenters had the opportunity to request a response from Project team members. No comment cards were returned to the Project team at the meeting. As of December 20, 2019, no comment cards have been returned to the Project team.

Oral Questions and Answers

Oral questions were asked by meeting attendees and the answers provided by Project team members included:

- **Is this pipeline going to carry fracking water?**
    - The Project is designed to transport production water from approximately 22 oil and gas production facilities in Adams and Weld Counties to Expedition's existing EWS #6 wastewater injection and disposal facility in Weld County. Most of the production water is groundwater from the rock formation; however, some water used during hydraulic fracturing will mix with groundwater during hydraulic fracturing and will be transported with groundwater to EWS #6.
- **What is in the water that is coming out of the wells?**
    - Production water, also known as wastewater, is recovered as byproduct that is brought to the surface during oil and gas production. Production water is sometimes referred to as brine

water. Brine water is twice as salty as sea water, and it naturally occurs within rock formations underground. For about one barrel of oil and gas produced by a well, approximately three barrels of brine water are also produced.

- **Will there be any pump stations on the pipeline route?**
    - No pump stations will be located on the pipeline route. The pumps for the pipeline will be located at the well sites where the water enters the pipeline. The pumps at those facilities produce enough pressure to push the water all the way to the disposal site in Weld County.
- **Where is the produced water going?**
    - The Project would transport production water with trace amounts of oil, gas, and chemicals to Expedition's existing EWS #6 wastewater injection and disposal facility in Weld County. EWS #6 would treat the water to remove the trace amounts of oil, gas and chemicals but leaves the salt in the water, which is then pumped back into the ground into a salt water aquifer. The injected water is similar in composition to the salt water aquifer.
- **Will there be any surface appurtenances along the pipeline route?**
    - Only a few surface structures would be located along the pipeline route. They will be safety shutoff stations that will generally be at a pipeline junction and where the pipeline changes diameter.
- **How wide will the pipeline easements and construction areas be?**
    - During construction a 40-foot-wide space will be needed along the Project pipeline for installation. At times, where the pipeline crosses roads or water ways, a larger construction area will be needed. Once completed, a 10-foot-wide permanent easement will be needed for the pipeline for its lifetime.
- **Will the water treatment site and injection facility be fracturing or fracking the rock where they inject?**
    - The pressure will be low enough that the rock will not be fractured, and the injection site is regulated by the State of Colorado and the U.S. Environmental Protection Agency.
- **What is the projected lifetime of the injection site?**
    - The injection site is currently estimated to have a lifespan of 20 years, and it has been in-service since July 2019.

- **When will the pipeline in Adams County be constructed?**
    - Construction of the Adams County portion of the pipeline is estimated to start in summer 2020 and is projected to be completed by the end of 2020.
- **What is the equivalent number of truck trips for 500 million truck miles removed annually?**
    - Based on full buildout of production facilities, the Project will remove around 160 truck trips per day, and it would increase the amount removed as more oil and gas facilities are constructed and connected to the pipeline.
- **What is the lifespan of an oil and gas well?**
    - The lifespan of oil and gas production facilities typically ranges from 10 to 30 years, but the lifespan depends on the well and the oil and gas available in the formation below each specific facility.
- **What is the water pipeline going to be constructed of?**
    - The pipeline will be constructed of 4- to 12 inch-diameter HDPE gathering pipelines.
- **Can they lay pipeline on my property without notifying me?**
    - No, Pioneer will btain easements signed by landowners for the entire Project route.
- **Would this Project be able to connect to future oil and gas production facilities if needed?**
    - Yes, this pipeline will have the capacity to carry produced water from future oil and gas facilities, depending on timing and location of those facilities.

Community & Economic
Development Department
Development Services Division
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ADAMS COUNTY
COLORADO

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PHONE 720.523.6800
FAX 720.523.6967

Request for Comments

Case Name: Pioneer Produced Water Pipeline CUP

Case Number: RCU2020-00004

March 4, 2020

The Adams County Planning Commission is requesting comments on the following application: **Conditional Use Permit to allow for a produced water pipeline.** The applicant has provided one preferred and two alternative routes for the pipeline. The Assessor's Parcel Numbers are: 156919000005, 156919000015, 156920000017, 156930000001, 157101200007, 157101300001, 157101300002, 157102100003, 157102100004, 157102101014, 157104100005, 157104200003, 157104300002, 157106000007, 157106000022, 157106001001, 157106001002, 157106300002, 157107000002, 157107000014, 157107000016, 157107000023, 157107400001, 157108000001, 157108000004, 157108200002, 157109202001, 157111100010, 157112000033, 157112000038, 157112010003, 157121000016, 157121000017, 157122000001, 157122103001, 157122103003, 157123000026, 157123401001, 157124000015, 157124000016, 157124000017, 157124000019, 157125000012, 157126101003, 157126201001, 157301000007, 157311400002, 157311400007, 157311400008, 157311400009

Applicant Information: Pioneer Water Pipeline, LLC
Spence McCallie
600 17th Street, Suite 725
Denver, Colorado 80202

Please forward any written comments on this application to the Community and Economic Development Department at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216 or call (720) 523-6800 by **03/27/2020** in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to GJBarnes@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional colored maps can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Greg Barnes
Planner III

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
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PHONE 720.523.6800
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Public Hearing Notification

Case Name:	Pioneer Produced Water Pipeline
Case Number:	RCU2020-00004
Planning Commission Hearing Date:	August 13, 2020 at 6:00 p.m.
Board of County Commissioners Hearing Date:	September 1, 2020 at 9:30 a.m.

July 17, 2020

A public hearing has been set by the Adams County Planning Commission and the Board of County Commissioners to consider the following request: Conditional Use Permit to allow for a produced water pipeline. The Assessor's Parcel Numbers are: 156919000005, 156919000015, 156920000017, 156930000001, 157101200007, 157101300001, 157101300002, 157102100003, 157102100004, 157102101014, 157104100005, 157104200003, 157104300002, 157106000007, 157106000022, 157106001001, 157106001002, 157106300002, 157107000002, 157107000014, 157107000016, 157107000023, 157107400001, 157108000001, 157108000004, 157108200002, 157109202001, 157111100010, 157112000033, 157112000038, 157112010003, 157121000016, 157121000017, 157122000001, 157122103001, 157122103003, 157123000026, 157123401001, 157124000015, 157124000016, 157124000017, 157124000019, 157125000012, 157126101003, 157126201001, 157301000007, 157311400002, 157311400007, 157311400008, 157311400009.

Applicant Information: Pioneer Water Pipeline, LLC
Spence McCallie
600 17th Street, Suite 725
Denver, Colorado 80202

The Planning Commission meeting will be held virtually using the Zoom video conferencing software and members of the public will be able to submit comments prior to the start of the public hearing that will then be entered into the record. For instructions on how to access the public hearing via telephone or internet, or to submit comment, please visit http://www.adcogov.org/planning-commission for up to date information.

The Board of County Commissioners meeting is broadcast live on the Adams County YouTube channel and members of the public will be able to submit comments prior to the start of the public hearing that will then be entered into the record. The eComment period opens when the agenda is published and

closes at 4:30 p.m. the Monday prior to the noticed meeting. For instructions on how to access the public hearing and submit comments, please visit http://www.adcogov.org/bocc for up to date information.

These will be public hearings and any interested parties may attend and be heard. The Applicant and Representative's presence at these hearings is requested. The full text of the proposed request and additional colored maps can be obtained by accessing the Adams County Community and Economic Development Department website at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Greg Barnes

Greg Barnes
Planner III
gjbarnes@adcogov.org
720-523-6853

PUBLICATION REQUEST

Case Name: PIONEER WATER PIPELINE
Case Number: RCU2020-00004
Planning Commission Hearing Date: August 13, 2020 at 6:00 p.m.
Board of County Commissioners Hearing Date: September 1, 2020 at 9:30 a.m.
Case Manager: Greg Barnes, gjbarnes@adcogov.org. 720-523-6853
Request: Conditional use permit to allow a produced water pipeline. The applicant has provided one preferred and two alternative routes for the pipeline.
Parcel Numbers: 0156919000005, 0156930000001, 0157101200007, 0157101300001, 0157101300002, 0157102100003, 0157102100004, 0157102101014, 0157104100005, 0157104200003, 0157104300002, 0157106000007, 0157106001001, 0157106001002, 0157107000002, 0157107000014, 0157107000016, 0157107000023, 0157107400001, 0157108000001, 0157108000004, 0157108200002, 0157112000033, 0157112000038, 0157112010003, 0157121000016, 0157121000017, 0157122000001, 0157122103001, 0157122103003, 0157123000026, 0157124000015, 0157124000016, 0157124000017, 0157124000019, 0157125000012, 0157126101003, 0157126201001, 0157311400002, 0157311400007, 0157311400008, 0157311400009
Applicant: Pioneer Water Pipeline, LLC, Spence McCallie, 600 17th St, Ste 725, Denver, CO 80202

Virtual Meeting and Public Comment Information:
These meetings will be held virtually. Please visit http://www.adcogov.org/planning-commission and http://www.adcogov.org/bocc for up to date information on accessing the public hearings and submitting comment prior to the hearings. The full text of the proposed request and additional colored maps can be obtained by accessing the Adams County Community and Economic Development Department website at www.adcogov.org/planning/currentcases.

Referral Listing
Case Number RCU2020-00004
PIONEER WATER PIPELINE PROJECT

Agency	Contact Information
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Adams County CEDD Right-of-Way	Marissa Hillje 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6837 mhillje@adcogov.org
Adams County Community Safety & Wellbeing, Neighborhood Services	Gail Moon gmoon@adcogov.org 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6856 gmoon@adcogov.org
Adams County Development Services - Building	Justin Blair 4430 S Adams County Pkwy Brighton CO 80601 720-523-6825 JBlair@adcogov.org
Adams County Parks and Open Space Department	Aaron Clark (303) 637-8005 aclark@adcogov.org
Adams County Parks and Open Space Department	Marc Pedrucci 303-637-8014 mpedrucci@adcogov.org
Adams County Sheriff's Office: SO-HQ	Rick Reigenborn (303) 654-1850 rreigenborn@adcogov.org

Agency	Contact Information
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BRIGHTON SCHOOL DISTRICT 27J	Kerrie Monti 1850 EGBERT STREET SUITE 140, BOX 6 BRIGHTON CO 80601 303-655-2984 kmonti@sd27j.net
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CDPHE - WATER QUALITY PROTECTION SECT	Patrick Pfaltzgraff 4300 CHERRY CREEK DRIVE SOUTH WQCD-B2 DENVER CO 80246-1530 303-692-3509 patrick.j.pfaltzgraff@state.co.us

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CITY OF THORNTON	JIM KAISER 12450 N WASHINGTON THORNTON CO 80241 720-977-6266
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Eagle Shadow Metro District 1/ Spencer Fane	JIM WORTHY 1700 Lincoln Street Suite 2000 Denver CO 80203 303-637-0344

Agency	Contact Information
HERITAGE AT TODD CREEK METRO DIST.	GARY BEUTLER 2154 E. Commons Ave. Suite 2000 Centennial CO 80122 303-868-8131
METRO WASTEWATER RECLAMATION	CRAIG SIMMONDS 6450 YORK ST. DENVER CO 80229 303-286-3338 CSIMMONDS@MWRD.DST.CO.US
NORTH METRO FIRE DISTRICT	Steve Gosselin 101 Lamar Street Broomfield CO 80020 (303) 452-9910 sgosselin@northmetrofire.org
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Riverdale Peaks Metro District	Lisa Johnson 141 Union Blvd, Suite 150 Lakewood CO 80228 303-987-0835 ljohnson@sdmsi.com
THORNTON FIRE DEPARTMENT	Chad Mccollum 9500 Civic Center Drive THORNTON CO 80229-4326 303-538-7602 firedept@cityofthornton.net
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AGGREGATE INDUSTRIES WCR INC
1687 COLE BLVD STE 300
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BRIGHTON CO 80602-7439

BLOOM KATHLEEN L
12500 E 160TH AVE
BRIGHTON CO 80602-8221

BLUNCK RODNEY AND
BLUNCK JULIE
8559 E 163RD COURT
BRIGHTON CO 80602

BOARD OF COUNTY COMMISSIONERS
COUNTY OF ADAMS
4430 S ADAMS COUNTY PKWY
BRIGHTON CO 80601

BOARD OF COUNTY COMMISSIONERS
COUNTY OF ADAMS
9755 HENDERSON RD
BRIGHTON CO 80601-8114

BOARD OF COUNTY COMMISSIONERS COUNTY OF ADAMS
4430 S ADAMS COUNTY PKWY FL 5
BRIGHTON CO 80601-8222

BOBO SYLVESTER AND
BOBO ALICE JOHNSON
9050 E 145TH AVE
THORNTON CO 80602-5694

BOCANEGRA RAYMUNDO D JR
SAENZ NORA C
13882 TAMARAC CT
THORNTON CO 80602-8437

BOEN KELLY DARNELL AND
BOEN JODIE SUE
14095 BRIGHTON RD
BRIGHTON CO 80601-7317

BOHLENDER DILLON JACOB
15576 QUINCE CIR
THORNTON CO 80602-8508

BOIES GARLAND D AND
KNIGHT-BOIES CINDY C
8021 E 139TH AVE
THORNTON CO 80602-8139

BOLGER JAMES AND
BOLGER DANIELLE
13885 TRENTON ST
THORNTON CO 80602-8507

BONNER DELBERT III AND
BONNER DANIELLE M
13875 TRENTON ST
THORNTON CO 80602-8507

BORDEN KENNETH W AND
BORDEN TAMARA L
13532 KENNEDY AVE
BRIGHTON CO 80601

BOULIER SHAUN A AND
BOULIER TAWNYA C
8005 E 139TH PL
THORNTON CO 80602-8145

BRANNAN SAND AND GRAVEL CO LLC
2500 E BRANNAN WAY
DENVER CO 80229

BRIGHTON DITCH COMPANY
3286 WELD COUNTY ROAD 23
FT LUPTON CO 80621

BRIGHTON FARM LLC
15600 HOLLY ST
BRIGHTON CO 80602-7911

BRIGHTON LAKES LLC
200 W HAMPDEN AVE STE 201
ENGLEWOOD CO 80110-2407

BROMLEY DISTRICT WATER PROVIDERS LLC
C/O BROMLEY COMPANIES LLC
8301 E PRENTICE AVE STE 100
GREENWOOD VILLAGE CO 80111-2904

BROOKS ADAM C AND
BROOKS TIFFANY R
8037 E 139TH PL
THORNTON CO 80602-8145

BROW GARY T AND
BROW DOROTHY J
7137 E 162ND COURT
BRIGHTON CO 80602

BROWN DOUGLAS W
16021 PONTIAC CT
BRIGHTON CO 80602-6077

BUCK ROBERT M AND
BUCK HANORA MASDIN
9010 E 139TH CT
BRIGHTON CO 80602-8237

BUDZYNSKI GREGORY J AND
BUDZYNSKI CHANTELLE M
8540 E 145TH PL
BRIGHTON CO 80602-5749

BUFFER KRISTIN AND
WAHLERS MATTHEW
15557 QUINCE ST
THORNTON CO 80602-8170

BULLER JAMES AND
BULLER MONA RAE
15571 RIVERDALE RD
BRIGHTON CO 80602-8226

BUNN WILLIAM P AND
BUNN SHERRI L
16610 STEELE ST
BRIGHTON CO 80602

BURKE JASON E
7901 E 139TH AVE
THORNTON CO 80602-8138

BURKE PHILIP J AND
BURKE JENNIFER K
15841 RIVERDALE RD
BRIGHTON CO 80602-8216

BUSTAM DAVID S AND
BARNUM MELISSA L
11123 E 163RD CT
BRIGHTON CO 80602-7569

CALAWAY PAIGE H
13936 TAMARAC CT
THORNTON CO 80602-8443

CALDWELL MICHAEL A JR AND
CALDWELL VERONICA I
7851 E 139TH AVE
THORNTON CO 80602-8136

CALHOON AARON J AND
CALHOON AUDRA L
15630 HAVANA WAY
BRIGHTON CO 80602

CAMAS COLORADO INC
C/O AGGREGATE INDUSTRIES
1687 COLE BLVD STE 300
GOLDEN CO 80401-3318

CAO ZUE FAN AND
LI FENG ZHU
15161 GAYLORD ST
THORNTON CO 80602-7471

CARABAJAL CARL A/IDA AND
CARABAJAL AMARANTE C
15625 HAVANA WAY
BRIGHTON CO 80602-7408

CARLSON BLAKE 25%/CARLSON SARA 25%
JUMPS BRIAN 25%/REED STEPHANIE 25%
10261 ARAPAHOE RD
LAFAYETTE CO 80026-9347

CARLSON EDWARD R AND
CARLSON TERRI LYNN
11741 KEARNEY CIR
THORNTON CO 80233-5211

CARLSON TAYLOR R UND 24.25% INT AND
THORNTON CORY J UND 24.25 INT ET ALS
PO BOX 247
EASTLAKE CO 80614-0247

CARLSON TAYLOR R UND 24.25% INT AND
THORNTON CORY J UND 24.25% INT ET ALS
PO BOX 247
EASTLAKE CO 80614-0247

CARLSON TAYLOR R UND 24.25% INT AND
THORNTON CORY J UN 24.25 INT ET ALS
PO BOX 247
EASTLAKE CO 80614-0247

CARNCROSS JASON T AND CARNCROSS CAROL L AND
ARMSTRONG ROBERT L AND ARMSTRONG PAMELA J
10010 E 142ND AVE
BRIGHTON CO 80602-5773

CARRIGAN DOUGLAS A AND
CARRIGAN CATHY L
16242 POPLAR ST
BRIGHTON CO 80602-6076

CASTILLO FRANK AND
CASTILLO TERRY
16012 OLIVE ST
BRIGHTON CO 80602-6002

CASTRO-ANGULO GAMALIEL AND
MARTINEZ MARIANA S
15160 GAYLORD ST
THORNTON CO 80602-7471

CASTRODALE PATRICIA
4 SEARS CT
KEOKUK IA 52632-2547

CC ERIE FARMS LLC UND 88% INT AND
HOLLY HOLDINGS LLC UND 12% INT
PO BOX 247
EASTLAKE CO 80614-0247

CERVANTES MARTIN ARMANDO
6880 NIAGARA ST
COMMERCE CITY CO 80022-2626

CESAR JAMES AND
CESAR GABRIELA M
7987 E 139TH PL
THORNTON CO 80602-8143

CHACON ROBERT
CHACON JENNIFER A
7811 E 139TH AVE
THORNTON CO 80602-8136

CHAPES STEPHEN K AND
SZYMANSKI LAURINE A
13896 SPRUCE ST
THORNTON CO 80602-8456

CHAPMAN LARY
15742 COLORADO BLVD
BRIGHTON CO 80602

CHAVIRA RAMON J AND
CHAVIRA AMANDA P
8031 E 139TH AVE
THORNTON CO 80602-8139

CHEN QINGCHEN AND
LIN LICHAI
15112 VINE WAY
THORNTON CO 80602-7472

CHEN SONG AND
HUANG CHUNMEI
11223 E 163RD CT
BRIGHTON CO 80602-7575

CHILDS CHARLES B AND
CHILDS MARY ELLEN
15531 QUINCE ST
THORNTON CO 80602-8170

CHIOVITTI NICHOLAS AND
CHIOVITTI DEBORAH MAE
15555 MONACO ST
BRIGHTON CO 80602

CHIOVITTI NICHOLAS AND DEBORAH M
15555 MONACO ST
BRIGHTON CO 80602

CHRISTENSEN CHAD A AND
CHRISTENSEN RACHAEL S
11473 E 163RD CT
BRIGHTON CO 80602-7579

CHRISTINO JOHN ANTHONY II AND
CHRISTINO ROBIN L
15567 SYRACUSE WAY
THORNTON CO 80602-8171

CHRISTOPHER EDWARD AND
CHRISTOPHER SANDRA
4600 E 168TH AVE
BRIGHTON CO 80602-6657

CIOCCA MARK A
15523 QUINCE CIR
THORNTON CO 80602-8508

CITY OF AURORA
15151 E ALAMEDA PKWY
AURORA CO 80012-1555

CITY OF AURORA
15151 E ALAMEDA PARKWAY 5TH FLOOR
AURORA CO 80012

CITY OF AURORA THE
15151 E ALAMEDA PKWY
AURORA CO 80012-1555

CITY OF BRIGHTON
500 S 4TH AVE
BRIGHTON CO 80601-3165

CITY OF BRIGHTON THE
500 S 4TH AVE
BRIGHTON CO 80601-3165

CITY OF THORNTON
9500 CIVIC CENTER DR
THORNTON CO 80229

CITY OF THORNTON
9500 CIVIC CENTER DR
DENVER CO 80229-4300

CITY OF THORNTON
9500 CIVIC CENTER DR
DENVER CO 80229-4326

CITY OF THORNTON
9500 CIVIC CENTER DR
THORNTON CO 80229-4326

CITY OF THORNTON THE
9500 CIVIC CENTER DR
THORNTON CO 80229-4326

CLARK KENDALL W AND
CLARK VERA E
16123 KRAMERIA CT
BRIGHTON CO 80602-7973

CLAUSEN MITCH L
8526 E 163RD AVE
BRIGHTON CO 80602

CLEM BRAD AND
CLEM MARY
7154 E 162ND AVE
BRIGHTON CO 80602-7594

CLEVELAND CHERYL L AND CLEVELAND JUSTIN M AND
CLEVELAND MARIA
8831 W KIOWA DR
BOISE ID 83709-6322

CLEVELAND RANDALL J AND
CLEVELAND LISA L
13521 SABLE BLVD
BRIGHTON CO 80601-7266

COBB MICHAEL J
7068 EAGLE SHADOW AVENUE
BRIGHTON CO 80602

COLLINS CHRISTIAN A AND
COLLINS BRANDI M
15645 HAVANA WAY
BRIGHTON CO 80602

COLORADO AND E-470 LLC
PO BOX 247
EASTLAKE CO 80614-0247

COMEAU DORSEY A AND
COMEAU MARYCATHERINE
13572 KENNEDY AVE
BRIGHTON CO 80601-6946

CONN DALE J AND
CONN JUDY L
16010 PONTIAC CT
BRIGHTON CO 80602-6082

CONNAUGHTON GLENN DAVID AND
CONNAUGHTON ELVIRA
7907 E 139TH PL
THORNTON CO 80602-8143

CONTRERAS JESUS M
PO BOX 33314
NORTHGLENN CO 80233-0314

CORCILIUS WILLIAM A
4200 E 168TH AVE
BRIGHTON CO 80602-6601

CORDOVA SERENA N AND
HEER DARREL D JR
7402 E 157TH PL
THORNTON CO 80602-8173

CORDOVA SILAS W AND
CORDOVA KELLY
13875 TAMARAC ST
THORNTON CO 80602-8477

COULL IAN D AND
COULL MARY ANN
16787 LANSING CT
BRIGHTON CO 80602-7980

COUNTY OF ADAMS
4430 SOUTH ADAMS COUNTY PKWY
BRIGHTON CO 80601-8204

COUNTY OF ADAMS
BOARD OF COUNTY COMMISSIONERS
4430 SOUTH ADAMS COUNTY PKWY
BRGHTON CO 80601-8204

COUNTY OF ADAMS
4430 S ADAMS COUNTY PKWY FL 5
BRIGHTON CO 80601-8222

COUNTY OF ADAMS THE
4430 SOUTH ADAMS COUNTY PKWY
BRIGHTON CO 80601-8204

COUNTY OF ADAMS THE
9755 HENDERSON RD
BRIGHTON CO 80601-8114

COX CHRISTOPHER CASEY
7858 E 139TH PL
THORNTON CO 80602-8141

COX PAMELA M AND
COX MICHAEL
5992 E 161ST AVE
BRIGHTON CO 80602-7964

CREEKSIDE SOUTH ESTATES METROPOLITAN DISTRICT
C/O SPECIAL DISTRICT MANAGEMENT SERVICES INC
LAKEWOOD CO 80228-1898

CROCKER DARREN AND
CROCKER LACY
14121 COUNTRY HILLS DR
BRIGHTON CO 80601-6711

CROWLE NELSON AND
VAN SANT CROWLE CAROLINE
16021 VERBENA ST
BRIGHTON CO 80602-7552

CULLEN JAMES AND
CULLEN CHRISTINA
11420 E 163RD CT
BRIGHTON CO 80602-7579

CURRAN BILL STUART AND
CURRAN PAMELA BETH
16070 POPLAR ST
BRIGHTON CO 80602-6079

DABROWSKI WOJCIECH
16287 MOLINE ST
BRIGHTON CO 80602

DAVIS RICHARD C AND
BROERSMA TERRI LYNNE
13675 BRIGHTON RD
BRIGHTON CO 80601-7326

DE LA CRUZ BRECEDA FERNANDO ARMANDO
16400 TUCSON ST
BRIGHTON CO 80601-8302

DEAN DALE MITCHELL AND
DEAN MAY MARIE
13880 BOSTON ST
BRIGHTON CO 80602-8208

DEAN JUSTIN AKA DEAN JUSTIN M AND
DEAN KRISTA AKA DEAN KRISTA S
16130 NEWARK ST
BRIGHTON CO 80602-8302

DEARDORFF DENNIS J AND
DEARDORFF DEBRA A W
13293 BRIGHTON RD
BRIGHTON CO 80601-7348

DEHELD PATRICK AND
DEHELD AMY
11230 E 163RD CT
BRIGHTON CO 80602-7575

DEKYONG TENZIN AND
LAMA TENZING
15501 QUINCE CIR
THORNTON CO 80602-8508

DELAROW AMY AND
DELAROW JESSICA MARIE
15103 VINE WAY
THORNTON CO 80602-7472

DELUISE KALON AND
DELUISE COLETTE
11200 E 166TH AVE
BRIGHTON CO 80602-7978

DELUZIO BRIAN J
16030 OAKLAND CT
BRIGHTON CO 80602-8296

DENCKLAU JAMES R
13895 QUEBEC ST
BRIGHTON CO 80602

DENNEY ERICA AND
DENNEY AARON
11575 E 162ND DR
BRIGHTON CO 80602-7684

DESABATTULA BALACHANDRA MOULI AND
DESABATTULA SUREKHA
15181 GAYLORD ST
THORNTON CO 80602-7471

DHANUJRATHNA SELVARAJ AND
SARAVANAN SELVAM
2068 E 151ST AVE
THORNTON CO 80602-7475

DICKEY JACOB M AND
DICKEY ERIN K
15695 QUINCE ST
THORNTON CO 80602-8174

DILL AMY ANNE
13850 RIVERDALE RD
BRIGHTON CO 80602-8255

DIMANNA TAMMY R AND
DIMANNA TERRY S
16275 NOME ST
BRIGHTON CO 80602-8301

DITTO PATRICK AND
DITTO JANIE
15147 VINE WAY
THORNTON CO 80602-7472

DO NGOC ANH T AND
LEE THOMAS T
8020 E 139TH AVE
THORNTON CO 80602-8139

DOBBINS CHRISTOPHER L AND
DOBBINS JILLIAN S
15851 RIVERDALE RD
BRIGHTON CO 80602-8216

DODRILL ROGER T III AND
DODRILL DANA L
15517 QUINCE CIR
THORNTON CO 80602-8508

DOLLINGER PAUL M AND DOLLINGER LAUREN C AND
DAHL LAWRENCE A AND DAHL JERRI E
16011 POPLAR ST
BRIGHTON CO 80602-6078

DORRANCE VINCENT
15669 QUINCE ST
THORNTON CO 80602-8174

DOYLE WILLIAM J AND
DOYLE JILL
9825 E 138TH PL
BRIGHTON CO 80602-8212

DRENNAN CHARLES AND
DRENNAN CHRISTEN
16125 OLIVE STREET
BRIGHTON CO 80602

DRESSLER WILLIAM R AND
DRESSLER DONNA L
14789 E 135TH AVE
BRIGHTON CO 80601-6920

DROZD KENNETH J
13540 SABLE BLVD
BRIGHTON CO 80601-7225

DUNHAM BOYD A AND
DUNHAM DONLEVA L
16792 POPLAR CT
BRIGHTON CO 80602-6032

E-470 PUBLIC HIGHWAY AUTHORITY
22470 E STEPHEN D HOGAN PKWY STE 100
AURORA CO 80018

EASTCREEK LLC
PO BOX 247
EASTLAKE CO 80614-0247

EDDY MICHAEL AND
GRIFFITH SARAH
7835 E 139TH PL
THORNTON CO 80602-8141

EDRICH JOEL
16151 VERBENA ST
BRIGHTON CO 80602-7552

EDWARDS PAUL E
1709 S FILLMORE ST
DENVER CO 80210-2946

EGAN ARTHUR G AND
EGAN EDNA R
4695 E 160TH AVE
BRIGHTON CO 80602

EGAN PHILLIP C AND EGAN CHRISTINE J
8420 E 160TH PL
BRIGHTON CO 80602-7557

EHA TIMOTHY AND
EHA BRANDY
2028 E 151ST AVE
THORNTON CO 80602-7475

ELAINE A SCHAEFER LIVING TRUST ET AL
13295 E 136TH AVE
BRIGHTON CO 80601-7281

ELAINE A SCHAEFER LIVING TRUST UND 1/2 INT A
ND
CARL RICHARD SCHAEFER TESTAMENTARY TRUST UND
1/2 INT
13295 E 136TH AVE
BRIGHTON CO 80601-7281

ELG INVESTORS LLC
10450 E 159TH CT
BRIGHTON CO 80602-7977

ELSHOF MICHAEL W AND
ELSHOF SARAH R
16002 OLIVE CT
BRIGHTON CO 80602-7599

ERMI CYNTHIA AND
ERMI MICHAEL
16081 VERBENA ST
BRIGHTON CO 80602-7552

ERN LIMITED PARTNERSHIP ET AL
7 CIRCLE DR
WHEAT RIDGE CO 80215-6607

FAILS KELLY R AND
FAILS SHANNON L
15935 ULSTER ST
BRIGHTON CO 80602-7546

FAIRFIELD HOMEOWNERS ASSOCIATION INC
8700 TURNPIKE DR STE 230
WESTMINSTER CO 80031-7029

FALLON JOHN AND
MENDELSON JESSICA
11270 E 163RD CT
BRIGHTON CO 80602-7575

FARLEY ZACKARY M AND
MC KILLOP MORGAN E
15140 GAYLORD ST
THORNTON CO 80602-7471

FEIS MARK J AND
FEIS KATHERINE A
15351 RIVERDALE RD
BRIGHTON CO 80602-8267

FERRELL TIMOTHY R AND
FERRELL CLAUDIA M
13785 POTOMAC ST
BRIGHTON CO 80601-7278

FIKE GERTRUDE L
13022 E 136TH AVE
BRIGHTON CO 80601-7281

FISCHER CYNDI AND
ROBERTS MIKE
15611 COLORADO BLVD
BRIGHTON CO 80602-7801

FISCHER CYNTHIA L AND
ROBERTS MICHAEL K
15611 COLORADO BLVD
BRIGHTON CO 80602

FISCHER CYNTHIA L AND
ROBERTS MICHAEL K
15611 COLORADO BLVD
BRIGHTON CO 80602-7801

FISH RYAN M AND
FISH SARAH J
16288 XENIA CT
BRIGHTON CO 80602-7586

FISK AARON M AND
JACKSON WYETH R
16051 PONTIAC COURT
BRIGHTON CO 80602

FLETCHER BRETT
13550 GRANBY ST
BRIGHTON CO 80601-6959

FLORMAN NANCY S
7857 E 139TH PL
THORNTON CO 80602-8141

FLOYD KIRSTEN L
13561 SABLE BLVD
BRIGHTON CO 80601-7266

FLYNN JAMES JR
11231 E 166TH AVE
BRIGHTON CO 80602-7978

FONTES JOSE C AND
FONTES MARIA L
8841 E 163RD PLACE
BRIGHTON CO 80602

FORLENZA RICHARD A AND
SMITH ROSWITHA
15516 QUINCE CIRCLE
THORNTON CO 80602

FORTERRA INVESTMENTS LTD
200 W HAMPDEN AVE STE 201
ENGLEWOOD CO 80110-2407

FOX FRIEDA AND
ZAMORA ANTHONY
8011 E 138TH PL
THORNTON CO 80602

FREDERICKSON SHAWN D AND
FREDERICKSON SARAH A
15820 ULSTER ST
BRIGHTON CO 80602-7543

FREEMAN WILLIAM C AND
FREEMAN LORETTA S
11080 E 155TH PL
BRIGHTON CO 80602-7446

FREI JOSEPH AND
FREI AMBER
10000 E 138TH PL
BRIGHTON CO 80602-8215

FREI THOMAS JACOB GST TRUST
7321 E 88TH AVE
HENDERSON CO 80640-8137

FRENCH JAMES R AND
FRENCH COURTNEY A
14020 COUNTRY HILLS DR
BRIGHTON CO 80601-6713

FRETTER LOIS
C/O CHRIS FRETTER
BRIGHTON CO 80602-5685

FREW JAMES THOMAS
16721 POPLAR CT
BRIGHTON CO 80602-6032

FRIEHAUF BRYAN K AND
FRIEHAUF TRACY L
11160 E 166TH AVE
BRIGHTON CO 80602-6614

FRISK MICHELLE B AND
FRISK SHANE R
10320 E 142ND AVE
THORNTON CO 80602-5774

FROTTEN THOMAS S
16122 OLIVE ST
BRIGHTON CO 80602-7598

FULTON DITCH CO
C/O BRICE STEELE
25 S 4TH AVE
BRIGHTON CO 80601-2029

FULTON IRRIGATION DITCH CO
13698 E 136TH AVE
BRIGHTON CO 80601

GANGER WILLIAM R JR
8446 EAST 163RD AVENUE
BRIGHTON CO 80602

GARCIA CHRISTOPHER V AND
GARCIA C MICHELLE
8510 E 145TH PLACE
BRIGHTON CO 80601

GARCIA DAVID D II
16102 OLIVE ST
BRIGHTON CO 80602-7598

GARRISON WILLIAM A
16221 POPLAR STREET
BRIGHTON CO 80602

GIACOMINO LORI M LIVING TRUST
9075 E 138TH CT
BRIGHTON CO 80602

GILL JONATHAN AND
GILL CHRISTEN
15102 VINE WAY
THORNTON CO 80602-7472

GIRODO KENNETH J AND
GIRODO BONNIE L
16279 XENIA CT
BRIGHTON CO 80602-7586

GIST ROBERT W AND
GIST TINA M
10280 E 142ND AVE
THORNTON CO 80602-5773

GLIDEWELL BRADLEY G AND
GLIDEWELL CRISTINA
11981 E 160TH AVENUE
BRIGHTON CO 80602

GOMEZ ELIZABETH A AND
GOMEZ HERMINIO G
16760 LANSING CT
BRIGHTON CO 80602-7980

GOMEZ MANUEL L AND
GOMEZ GRISELDA J
7845 E 139TH PL
THORNTON CO 80602-8141

GOMEZ RECENDEZ ARTURO AND
GOMEZ RAMIREZ ANDY
15122 VINE WAY
THORNTON CO 80602-7472

GONZALES CHARLES AND
GONZALES LISA
16021 OAKLAND CT
BRIGHTON CO 80602-8296

GONZALES JOSE AND
GONZALES JENNIE J
PO BOX 1217
BRIGHTON CO 80601

GONZALES JOSEPH A AND
ROYBAL IRAYA S
7848 E 139TH PL
THORNTON CO 80602-8141

GONZALEZ GALINDO L
13182 GRAPE CT
THORNTON CO 80241-2317

GONZALEZ-MILLAN JONATHAN AND
GARZA BIANCA RUBY
13530 SABLE BLVD
BRIGHTON CO 80601-7225

GOOD FREDERICK RANDALL AND
GOOD JENNIFER J
2029 E 151ST AVE
THORNTON CO 80602-7475

GORMAN THOMAS F JR AND
GORMAN JONI M
7808 E 139TH PL
THORNTON CO 80602-8141

GOVARDHANAM KRISHAPRASAD
DINGIRI RADHIKA
15111 GAYLORD ST
THORNTON CO 80602-7471

GREEN RICHARD E AND
GREEN MICHELE L
15121 GAYLORD ST
THORNTON CO 80602-7471

GREENBURG THOMAS ARNOLD JR AND
GREENBURG KATHLEEN GEAN
11180 E 166TH AVE
BRIGHTON CO 80602-6614

GREENE BRIAN C AND
GREENE KORI C
8050 E 139TH AVE
THORNTON CO 80602-8139

GRENHAM OLIVER M AND
GRENHAM KELLY A
13950 BOSTON STREET
BRIGHTON CO 80601

GRIFFITH FAMILY TRUST THE
16262 POPLAR ST
BRIGHTON CO 80602-6076

GRIFFITH RANDAL P AND
GRIFFITH COLLEEN G
14501 AKRON ST
THORNTON CO 80602-5692

GRIZZLY PETROLEUM COMPANY LLC
1001 17TH ST FL 20
DENVER CO 80202-2035

GUZMAN ENRIQUE PEREZ AND
VARELA ROSARIO AIDE ORTIZ
3799 E 64TH AVE
COMMERCE CITY CO 80022-2210

H F INVESTMENT COMPANY LLC
13022 E 136TH AVE
BRIGHTON CO 80601-7281

HAGAN GILBERT SCOTT
11287 E 162ND PL
BRIGHTON CO 80602-8229

HALBROOK TERRY L AND
HALBROOK KRISTEL
7084 E 162ND AVE
BRIGHTON CO 80602-7594

HALE ARTHUR A AND
HALE VIRGINIA L
14120 COUNTRY HILLS DR
BRIGHTON CO 80601-6714

HAMMANG MARK W AND HAMMANG LEONARD WAYNE AND
HAMMANG LINDA LEE
11051 E 166TH AVE
BRIGHTON CO 80602-6603

HANCOCK FORREST AND
HANCOCK KOLLEEN
16254 PARIS WAY
BRIGHTON CO 80602-8299

HANGAR 160 LLC
8450 E CRESCENT PKWY STE 200
GREENWOOD VILLAGE CO 80111-2816

HARDING DEBRA J
5585 E 160TH AVE
BRIGHTON CO 80602

HARGER FAMILY TRUST
11247 E 162ND PL
BRIGHTON CO 80602-8229

HARMS LUISA
16347 PARIS WAY
BRIGHTON CO 80602-8298

HARRIS AUSTIN
8670 E 145TH PLACE
BRIGHTON CO 80601

HARRIS JASON MIKEL
7877 E 139TH PL
THORNTON CO 80602-8141

HARRISON BEVERLY
3476 COUNTY ROAD KK.75
FOWLER CO 81039-9713

HART DARRELL LAVERN
15864 RIVERDALE ROAD
BRIGHTON CO 80602

HART RONALD J
11026 TRACEY CT
NEW PORT RICHEY FL 34654-1517

HARTMANN DALE
16387 PARIS WAY
BRIGHTON CO 80602-8298

HARWOOD STEPHEN R
15661 COLORADO BLVD
BRIGHTON CO 80602-7801

HASSAN ASHRAF G AND
HAMEL ANGELA MARIE
15542 QUINCE ST
THORNTON CO 80602-8170

HAVANA AND ILIFF LLC
18685 EAST PLAZA DR
PARKER CO 80134

HAYS IAN AND
HAYS DRITA
7950 E 139TH AVE
THORNTON CO 80602-8138

HAZEL TIMOTHY D AND
HAZEL JULIE ANN
16780 POPLAR CT
BRIGHTON CO 80602-6032

HEADRICK CRAIG L AND
HEADRICK JANELLE C
11433 E 163RD CT
BRIGHTON CO 80602

HEALE SCOTT A AND
HEALE CAMMIE DAWN-ELLEN
15510 QUINCE CIR
THORNTON CO 80602-8508

HEDDINGS JASON AND
HEDDINGS ERICA
8457 E 163RD AVE
BRIGHTON CO 80602-7564

HEISER DAVID L AND
HEISER CHRISTINE A
11545 E 162ND DR
BRIGHTON CO 80602-7684

HENDERSON AGGREGATE LTD
7321 E 88TH AVE STE 100
HENDERSON CO 80640-8137

HENDERSON AGGREGATE LTD
7321 E 88TH AVE
HENDERSON CO 80640-8137

HENDERSON AGGREGATE LTD
PO BOX 700
HENDERSON CO 80640-9329

HENDERSON AGGREGATE LTD
PO BOX 700
HENDERSON CO 80640

HENDERSON REBECCA
14041 COUNTRY HILLS DR
BRIGHTON CO 80601-6712

HENDERSON ROBERT P AND
HENDERSON JENNIFER L
11183 E 163RD CT
BRIGHTON CO 80602-7569

HENLEY BRIAN L JR AND
HENLEY AMANDA C
8045 E 139TH PL
THORNTON CO 80602-8145

HER PAUL AND
YANG SHENG
13895 TRENTON ST
THORNTON CO 80602-8507

HERITAGE TODD CREEK METRO DISTRICT
C/O SETER & VANDER WALL PC
7400 E ORCHARD RD STE 3300
GREENWOOD VILLAGE CO 80111-2545

HERNANDEZ-ALVAREZ MONICA N AND
OLVERA-ROJAS JORGE E
9935 E 138TH PL
THORNTON CO 80602-8214

HERR FAMILY LLC
14378 HANOVER ST
BRIGHTON CO 80602-5782

HERTZ FAMILY TRUST THE
9125 E 138TH CT
BRIGHTON CO 80602-8201

HIGH PLAINS WATER USERS
ASSOCIATION
PO BOX 39
EASTLAKE CO 80614-0039

HINTON PHILIP J AND
HINTON CARIE ANN
13876 TAMARC ST
THORNTON CO 80602

HODGSON CHRISTOPHER LEE
HODGSON SABRINA RENEE
16137 PARIS WAY
BRIGHTON CO 80602-8297

HOLLAND RODNEY L AND
HOLLAND LINDA M
14709 E 135TH AVE
BRIGHTON CO 80601-6920

HOOD JAMES A AND
HOOD TERESA L
811 S 6TH AVE
BRIGHTON CO 80601-3213

HT PARTERRE LAND LP
609 MAIN ST STE 4400
HOUSTON TX 77002-3169

HTC GOLF ACQUISITIONS LLC
10450 E 159TH CT
BRIGHTON CO 80602

HUCK ROBERT A AND
HUCK KELLY R
8215 E 159TH CT
THORNTON CO 80602-7532

HUFFAKER LORI E AND
HUFFAKER ERIN
16231 VERBENA STREET
BRIGHTON CO 80602

HUFFMAN MATTHEW
KRAKORA NICOLE
15605 HAVANA WAY
BRIGHTON CO 80602-7408

HUNTING WENDY R
15643 QUINCE ST
THORNTON CO 80602-8174

HUTCHINSON JENNIFER J AND
SPETALIERI ALLISON M
7403 E 157TH AVE
THORNTON CO 80602-8172

IN SHATHA FAREED JERIES ALSAMA
8011 E 139TH AVE
THORNTON CO 80602-8139

J & R FARM LLC
602 SHADYCROFT LN
LITTLETON CO 80120-4070

JACKSON BROOK AND
JACKSON AUSTIN
15574 QUINCE CIR
THORNTON CO 80602-8508

JACKSON LARRY DEAN AND ROSEMARY
13510 FAIRPLAY ST
BRIGHTON CO 80601-6954

JACOBSEN BRITTNEY AND
JACOBSEN TATE J
16740 LANSING CT
BRIGHTON CO 80602-7980

JARAMILLO JOSE J AND
CANCHOLA DELFINA
16025 IVANHOE ST
BRIGHTON CO 80602

JENSEN BRUCE A AND
JENSEN KARLA K
7188 E 163RD AVE
BRIGHTON CO 80602-7699

JENSEN DENISE M AND
JENSEN WILLIAM P
8730 E 145TH PLACE
BRIGHTON CO 80601

JESSEN COLIN S AND
JESSEN JESSICA R
11583 E 163RD CT
BRIGHTON CO 80602

JOHNSON CALEB AND
JOHNSON DANIELL A
16215 NOME ST
BRIGHTON CO 80602-8301

JOHNSON DAVID P AND KIMBERLY L
10881 E 155TH PL
BRIGHTON CO 80602-7443

JOHNSON DONALD R JR AND
JOHNSON PAULA
15703 QUINCE ST
THORNTON CO 80602-8309

JOHNSON JAY PATRICK AND
JOHNSON ANGELA MARIE
16634 POPLAR CT
BRIGHTON CO 80602-6031

JOHNSON MARK J AND
JOHNSON DIANE L
11051 E 155TH PL
BRIGHTON CO 80602-7452

JONES BRIAN D AND
JONES SHERYL A
16072 OLIVE ST
BRIGHTON CO 80602-7598

JONES CHRISTOPHER P AND
JONES ANTOINETTE R
10943 E 163RD CT
BRIGHTON CO 80602

JONES DONALD AND
TAING VIOLETTA
15507 QUINCE CIR
THORNTON CO 80602-8508

JONES FRANKLIN D AND
JAMISON MARIA G
11253 E 163RD CT
BRIGHTON CO 80602-7575

JONES HOWARD MARION SR AND
JONES HOWARD M JR
14767 E 134TH PL
BRIGHTON CO 80601-6940

JONES LINDSEY AND
JONES MICHAEL
13885 TAMARAC ST
THORNTON CO 80602-8477

JRE 85 LLC
9377 E 147TH PL
BRIGHTON CO 80602-5713

JUAREZ BARBARA J
13481 SABLE BLVD
BRIGHTON CO 80601-7219

K-T FARM LLC
15571 RIVERDALE RD
BRIGHTON CO 80602-8226

KAHLER DONOVAN AND
CHANTHIVONG INKHAM
16052 OLIVE ST
BRIGHTON CO 80602-6002

KARGAER ABDUL MUMTAZ AND
KARGAR LOUDMELA
13946 TAMARAC CT
THORNTON CO 80602-8443

KARL JUSTINE M AND
LOMBARDI GEORGE A
15880 COLORADO BLVD
BRIGHTON CO 80602-7806

KARL MICHAEL G AND
KARL SHAWNA LEA
13490 KENNEDY AVENUE
BRIGHTON CO 80601

KARSTEN JONATHAN AND
KARSTEN ROBYN
16330 NOME ST
BRIGHTON CO 80602-8300

KEICHER JEFFREY M/MUNSON SUSAN M
50% INT AND SCHREYER HELEN B 50% INT
13677 CHERRY ST
THORNTON CO 80602

KELLEY CURTIS AND
KELLEY VANESSA
11343 E 163RD CT
BRIGHTON CO 80602-7578

KELLEY RODNEY D
15891 RIVERDALE RD
BRIGHTON CO 80602-8216

KELLEY ROGER L AND CARLA R
8155 E 159TH CT
BRIGHTON CO 80602

KELLY ROBERT S AND
KELLY CAROL ANN
7187 E 162ND CT
BRIGHTON CO 80602-8069

KELSEY RICHARD A AND
KELSEY DEANNA M
7900 E 139TH AVE
THORNTON CO 80602-8138

KHANTHAVONG SAENG AND
KHANTHAVONG SAENGJOY AND KHANTHAVONG BRENDA
8771 E 163RD PL
BRIGHTON CO 80602-7572

KIRK ROBERT J AND
KIRK AMELIA A
13886 TAMARAC ST
THORNTON CO 80602-8474

KIRKMAN DAVID
11180 E 163RD CT
BRIGHTON CO 80602-7569

KIRKPATRICK KEVIN AND
KIRKPATICK JAMIE
8047 E 139TH PL
THORNTON CO 80602-8145

KOLANO MICHAEL A AND BONNIE G
11151 E 155TH PL
BRIGHTON CO 80602

KONDORF PETER AND
KONDORF MICHELLE
6052 E 161ST AVE
BRIGHTON CO 80602-7964

KORTUM ACRES INC
1096 SEA SHELL CT
DAYTONA BEACH FL 32124-3731

KRAMER DEREK A AND
KRAMER DEBRA A
10801 E 155TH PL
BRIGHTON CO 80602

KRAMERS LEILA M AND
ZOPES MICHAEL L
16380 PARIS WAY
BRIGHTON CO 80602-8298

KROLL MICHAEL H AND
KROLL DONNA M
7120 EAGLE SHADOW AVE
BRIGHTON CO 80602-6000

KULKARNI AJINKYA AND
MULEY KETKI
2038 E 151ST AVE
THORNTON CO 80602-7475

KUSEK JEWEL AND
KUSEK EDWARD ALAN
16164 PARIS WAY
BRIGHTON CO 80602-8297

LAMBERT JAMES DONALD 1/2 INT AND
LAMBERT BARBARA JEAN 1/2 INT
11660 E 160TH AVE
BRIGHTON CO 80602-7437

LAMBERT JAMES DONALD 1/2 INT AND
LAMBERT BARBARA JEAN 1/2 INT
155 E BRIDGE ST
BRIGHTON CO 80601-1612

LAMPSHIRE RICHARD WILLIAM AND
LAMPSHIRE HILLARY NAGEL
11663 E 163RD CT
BRIGHTON CO 80602

LANGE FAMILY TRUST
8280 E 145TH PL
BRIGHTON CO 80602-5766

LARSEN DALE R AND
LARSEN VIVIAN L
14060 COUNTRY HILLS RD
BRIGHTON CO 80601-6713

LASS DANIEL WILLIAM AND
LASS SUE ANN
16767 LANSING CT
BRIGHTON CO 80602-7980

LAVELY MATTHEW AND
LAVELY BRENDA
14648 E 135TH AVE
BRIGHTON CO 80601

LE BAO CHAU P
14025 FLORENCE CT
BRIGHTON CO 80602-7033

LE CHAU B
987 HIGHWAY 85
BRIGHTON CO 80603

LEE CHRISTA L
13867 TAMARAC ST
THORNTON CO 80602-8477

LEE TOU
LEE KONG
8048 E 139TH PL
THORNTON CO 80602-8145

LEFEBVRE MELANIE
7951 E 139TH AVE
THORNTON CO 80602-8138

LEFEVRE FAMILY TRUST THE
8538 E 163RD CT
BRIGHTON CO 80602-7573

LEMAY BODEN J AND
LEMAY KATHY D
16740 POPLAR CT
BRIGHTON CO 80602-6032

LILLARD MULLIN FAMILY LIVING TRUST
14080 COUNTRY HILLS DR
BRIGHTON CO 80601-6713

LINK CORY M AND
LINK NATASHA A
11680 E 163RD CT
BRIGHTON CO 80602-7504

LLOYD BRUCE MICHL
12202 E 168TH AVE
BRIGHTON CO 80602-6661

LMB CAPITAL PARTNERS LLC
905 W 124TH AVE SUITE 200
WESTMINSTER CO 80234

LOCKETT KEVIN LEE
12302 E 168TH AVE
BRIGHTON CO 80602

LOCKETT KEVIN LEE
12302 E 168TH AVE
BRIGHTON CO 80602-6627

LOLLAR JIMMIE D
LOLLAR KAREN L
15491 RIVERDALE RD
BRIGHTON CO 80602-8231

LOMBARDI BRIGHTON PROPERTIES LLC
15800 COLORADO BLVD
BRIGHTON CO 80602-7806

LOMBARDI GEORGE/DIANE LIVING TRUST THE
15840 COLORADO BLVD
BRIGHTON CO 80602-7806

LONG DENNIS E AND
LONG PAMELA J
7897 E 139TH PL
THORNTON CO 80602

LOR XENG AND
PHOMMATHA SIVONE
13900 TAMARAC ST
THORNTON CO 80602-8506

LORSHBOUGH MARY J
15280 E 136TH AVE
BRIGHTON CO 80601-6955

LOVATO TIMOTHY MICHAEL AND
LOVATO CHRISTINE
13886 SPRUCE ST
THORNTON CO 80602-8456

LUCAS NATASHA AND
LUCAS DAVID
16257 PARIS WAY
BRIGHTON CO 80602-8299

LUCIO JOE LOUIS
4705 E 168TH AVENUE
BRIGHTON CO 80602

LUNDGREN JUDITH ANN AND
BUCZEK JANET AND MCKEE LARRY A
8556 E 163RD AVE
BRIGHTON CO 80602-7563

LYONS SADIE AND
LYONS JEFFREY D
14740 E 136TH AVE
BRIGHTON CO 80601-6958

MACIAS HELEN R AND
MACIAS ROBERT A
16080 OAKLAND CT
BRIGHTON CO 80602-8296

MANGUS GERALD H AND
MANGUS RAMONA R
16144 PARIS WAY
BRIGHTON CO 80602-8297

MANZANARES GABRIEL AND
MANZANARES ANNA MARIE
10240 E 142ND AVE
BRIGHTON CO 80602-5773

MARES FERNANDO MARTINEZ AND
MARTINEZ LILIANA D
13965 FLORENCE CT
BRIGHTON CO 80602-7070

MARSHALL MATTHEW A AND
WEBER ANNAMERIE
7898 E 139TH PL
THORNTON CO 80602-8141

MARTIN DANIEL A AND
MARTIN KRISTEN C
7867 E 139TH PL
THORNTON CO 80602-8141

MARTINEZ ROBERT AND
MARTINEZ MARGIE L
13876 TRENTON ST
THORNTON CO 80602-8507

MARTINEZ STEVEN LEROY AND
MARTINEZ SUSAN M
15509 QUINCE CIR
THORNTON CO 80602-8508

MASCARENAS STEVEN L AND
GARCIA DEBBIE L
PO BOX 1323
EASTLAKE CO 80614

MASSIER FAMILY TRUST
15460 KINGSTON ST
BRIGHTON CO 80602-7441

MAXWELL JOSEPH P AND
MAXWELL DIANE M
8586 E 163RD AVE
BRIGHTON CO 80602-7563

MC CRORY LAND AND CATTLE LLC
16155 HIGHWAY 7
BRIGHTON CO 80602-7648

MC DONALD GEORGE
7500 E 100TH AVE
HENDERSON CO 80640

MC DOWELL GORDON W AND
MC DOWELL RHONDA R
14221 EMPORIA STREET
BRIGHTON CO 80602

MC INTOSH THOMAS E
2500 FAIRPLAY WAY
AURORA CO 80011-2999

MC NURLIN DAVID D AND
MC NURLIN KIRSTEN A
15655 HAVANA WAY
BRIGHTON CO 80602-7415

MCCAULEY SUSAN JALAYNE LIVING TRUST
441 S 7TH AVE
BRIGHTON CO 80601-3107

MCCRORY J P
16152 MCCRORY CT
BRIGHTON CO 80602-8330

MCFARLAND CHARLES D AND
MCFARLAND SHARON A
11101 E 155TH PLACE
BRIGHTON CO 80602

MCKINNEY LARRY L AND
TAYLOR KIRSTY L
14707 E 134TH PL
BRIGHTON CO 80601-6940

MCLAUGHLIN KARLIN RAE AND
MCLAUGHLIN DAVID JAMES
15578 QUINCE ST
THORNTON CO 80602-8170

MCMILLAN MARK D
16717 LANSING CT
BRIGHTON CO 80602-7980

MCRAE-INGRAM JULIANE
16184 PARIS WAY
BRIGHTON CO 80602-8297

MCWILLIAMS NATHANIEL CHARLES AND
DIGHERO LINDSAY NICOLE
15136 VINE WAY
THORNTON CO 80602-7472

MEDLIN WAYNE E AND
MEDLIN PATRICIA L
15655 RIVERDALE RD
BRIGHTON CO 80602-8216

MEDLIN WAYNE E AND PATRICIA L
15655 RIVERDALE ROAD
BRIGHTON CO 80601

MEINECKE MICHAEL E AND
WEAVER KARYN G
11415 E 162ND DR
BRIGHTON CO 80602-7658

MELODY HOMES INC
C/O GEORGE MCELROY & ASSOCCIATES
AURORA CO 80014-3509

MELODY HOMES INC
C/O GEORGE MCELROY & ASSOCIATES INC
AURORA CO 80014-3509

MERRITT REAL ESTATE INVESTORS LLC
303 S BROADWAY
DENVER CO 80209-1558

METCALF ANNETTE L AND
GRIFFIN MICHAEL S
11071 E 166TH AVE
BRIGHTON CO 80602-6603

MINZAK BRYAN P AND
MINZAK KIMBERLY A
8021 E 138TH PL
THORNTON CO 80602

MOHAR ADALBERTO
15650 HAVANA WAY
BRIGHTON CO 80602-7409

MOHRLANG KATHERINE MARIE
8175 E 159TH CT
BRIGHTON CO 80602

MOLLEVIK MICHAEL T AND
MOLLEVIK KELLY L
4993 E 111TH PL
DENVER CO 80233-3815

MOLLICONI SANDRA
16227 PARIS WAY
BRIGHTON CO 80602-8299

MONROE JUDITH M
7149 E 163RD AVE
BRIGHTON CO 80602-7698

MONTOYA ANTHONY S/SHARON L AND
SOLANO ANTHONY W/NICOLE R
11550 E 163RD CT
BRIGHTON CO 80602-7599

MONTOYA ROBERT JAMES II AND
MONTOYA CHRISTY
11633 E 163RD CT
BRIGHTON CO 80602

MOORE CAMRON AND REGINA TRUST
11120 E 163RD CT
BRIGHTON CO 80602-7569

MORADO RODOLFO JR
8051 E 139TH AVE
THORNTON CO 80602-8139

MORELLO KIMBERLY
8509 E 163RD CT
BRIGHTON CO 80602-7573

MORGAN BARBARA A
13832 TAMARAC CT
THORNTON CO 80602

MORRIS STEPHEN C AND
MORRIS MELISSA
9025 E 138TH COURT
BRIGHTON CO 80602

MORRISON LYNNETTE
2131 S COOK ST
DENVER CO 80210-4913

MOSHER RICHARD J AND
KANAGAINTHIRAM RAMANI K
8050 E 136TH DR
THORNTON CO 80602-8106

MOUNTAIN VIEW WATER USERS
ASSOCIATION
PO BOX 485
BRIGHTON CO 80601

MRFR III LLLP
200 W HAMPDEN AVE STE 201
ENGLEWOOD CO 80110-2407

MUHLER WAYNE C AND
MUHLER KAREN A
12310 E 168TH AVE
BRIGHTON CO 80602-6627

MULLEN SHELLY K AND
MULLEN BRENT M
8580 E 145TH PLACE
BRIGHTON CO 80601

MURTHA KATHLEEN M
15430 KINGSTON ST
BRIGHTON CO 80602-7441

MUSE KURT W AND
MUSE KELLY R
13921 TAMARAC ST
THORNTON CO 80602-8506

MYER SANDRA K AND
MYER JUSTIN E
16610 POPLAR CT
BRIGHTON CO 80602-6031

NESS CHRISTOPHER
15861 RIVERDALE RD
BRIGHTON CO 80602-8216

NEUFELD PHILLIP/DEBORAH AND
NEUFELD CHRISTOPHER/PATRICK
9060 E 139TH CT
BRIGHTON CO 80602-8207

NEUFER MICHAEL EARL AND
NEUFER SONA
15518 QUINCE CIR
THORNTON CO 80602-8508

NGUYEN NICHOLAS T AND
NGUYEN THANH-TAM T
7855 E 139TH PL
THORNTON CO 80602-8141

NGUYEN THO L
15522 QUINCE CIR
THORNTON CO 80602-8508

NICHOLSON RONALD D AND
NICHOLSON TAMMY S
16299 XENIA COURT
BRIGHTON CO 80602

NICKERSON JEREMY C AND
NICKERSON DESIREE AND MARTINEZ DIANA
15558 QUINCE ST
THORNTON CO 80602-8170

NIELSEN BLAKE C AND
NEILSEN JENNY M
7967 E 139TH PL
THORNTON CO 80602-8143

NIXON GARY N AND
NIXON NANCY R
13464 CRYSTAL ST
BRIGHTON CO 80601-7269

NOBITT MICHAEL J AND
NOBITT ANDI L
7254 EAGLE SHADOW AVE
BRIGHTON CO 80602-6000

NORRIS KIMBERLY S
7888 E 139TH PL
THORNTON CO 80602-8141

NORTHERN HILLS CHRISTIAN CHURCH
5061 E 160TH AVE
BRIGHTON CO 80602

NUNN STEVEN M AND PAMELA K
15160 RIVERDALE RD
BRIGHTON CO 80601-8241

NYLANDER ERIK W AND
NYLANDER JENNIFER M
7095 E 162ND AVENUE
BRIGHTON CO 80602

O NEILL LEONARD L AND
O NEILL SHEILA JO
15700 COLORADO BLVD
BRIGHTON CO 80602-7806

OBLAS BRIAN
15564 QUINCE ST
THORNTON CO

OLD SCOTT FARM LLC
5290 DTC PKWY STE 150
ENGLEWOOD CO 80111-2764

OLIVAS GREGORY K
13475 FAIRPLAY ST
BRIGHTON CO 80601-6952

OLSAVSKY ALAN J AND
OLSAVSKY MARY J
16297 PARIS WAY
BRIGHTON CO 80602-8299

ORTIZ JOHN C AND
ORTIZ LESLIE
11141 E 166TH AVE
BRIGHTON CO 80602-6614

OSTROM MICHAEL J AND
OSTROM STEPHANIE
11393 E 163RD CT
BRIGHTON CO 80602-7578

PAICURICH EIRC ALAN AND
SCHERTZ VICKI JO
2168 E 151ST AVE
THORNTON CO 80602-7476

PALIZZI FARMS LLC
C/O DEBORA M PALIZZI AND GLORIA A BENNET
14820 SABLE BLVD
BRIGHTON CO 80601

PANCHAL RAVI CHANDRAKANT AND
VAGHELA MITAL NATVARLAL
2108 E 151ST AVE
THORNTON CO 80602-7476

PAPPAS MICHAEL J AND
PAPPAS MICHELLE A
16150 IVANHOE ST
BRIGHTON CO 80602-7982

PASCHEN RONALD L AND
PASCHEN WILLIAM P
16050 POPLAR ST
BRIGHTON CO 80602-6079

PAVELKA HENRY D AND
PAVELKA DENISE G
16142 OLIVE ST
BRIGHTON CO 80602-7598

PECK RYAN E AND
PECK ROBIN L W DANNI
5901 E 160TH PLACE
BRIGHTON CO 80602

PEDRIANES AUDYS O/RAFAEL AND
PEDRIANES LISA A
8038 E 139TH PL
THORNTON CO 80602-8145

PEGRAM RICK RYAN II AND
REUTERSKIOLD DEIDRA ALISON
7818 E 139TH PL
THORNTON CO 80602-8141

PERKINS DONALD E AND
PERKINS IRIS REIKO
15116 VINE WAY
THORNTON CO 80602-7472

PETERSEN RICHARD F AND
PETERSEN MARY N FAMILY TRUST
9600 LOWELL CT
WESTMINSTER CO 80030-2608

PETERSON HARREL H AND
KEATON AMBER B
8010 E 139TH AVE
THORNTON CO 80602-8139

PETERSON LANA MARIE AND
PETERSON ERIK ROGER
2058 E 151ST AVE
THORNTON CO 80602-7475

PETROCCO ALBERT J JR
PO BOX 459
HENDERSON CO 80640-0459

PETROCCO DOMINIC A 1/3/PETROCCO FAMILY
PARTNERSHIP 1/3/PETROCCO ALBERT J 1/3
14110 BRIGHTON ROAD
BRIGHTON CO 80601

PETROCCO FAMILY LIMITED PARTNERSHIP LLC
14110 BRIGHTON RD
BRIGHTON CO 80601-7318

PETROCCO FAMILY LIMITED PARTNERSHIP LLLP
14110 BRIGHTON RD
BRIGHTON CO 80601

PETROCCO JOSEPH P AND
PETROCCO EWA
15970 JACKSON ST
BRIGHTON CO 80602-7795

PJDS FAMLY TRUST THE
9845 E 138TH PL
BRIGHTON CO 80602

PLAMBECK BRIAN S AND
PLAMBECK RHONDA
7176 E 162ND CT
BRIGHTON CO 80602-8069

PLATEK MICHAL PAWEL AND
PLATEK SYLVIA
7827 E 139TH PL
THORNTON CO 80602-8141

PLATTE RIVER FARMS LLC
PO BOX 247
EASTLAKE CO 80614-0247

PLAZA WEST 20 LLC
9377 E 147TH PL
BRIGHTON CO 80602

POLAND DUSTIN AND
POLAND MELISSA
16268 XENIA CT
BRIGHTON CO 80602-7586

POMPEY KAREN A AND
BRUNTZ RANDY G
16696 POPLAR CT
BRIGHTON CO 80602-6031

PONUGOTI SUDHEER
PONUGOTI PRAVEENA
15131 GAYLORD ST
THORNTON CO 80602-7471

POPISH PHILIP H AND
POPISH SHARON L
14649 E 135TH AVE
BRIGHTON CO 80601-6918

PORTFLIET MATTHEW P VAN
PORTFLIET PATRICIA L VAN
13926 TAMARAC CT
THORNTON CO 80602-8443

POSTLE DEVELOPMENT COMPANY
PO BOX 1024
NIWOT CO 80544-1024

POWELL ARLEN AND
POWELL ROSEMARY
9955 E 138TH PL
BRIGHTON CO 80602-8214

PREBLE ANDREW AND
PREBLE ANNE
13920 TAMARAC ST
THORNTON CO 80602-8506

PRICE MARSHA R AND
JUDD TAMMY R
16131 VERBENA STREET
BRIGHTON CO 80602

QUEBEC 7 LLC
14642 STELLAS MEADOW DR
BROOMFIELD CO 80023-8401

QUEBEC HIGHLANDS HOMEOWNERS ASSOCIATION INC
PO BOX 3599
ENGLEWOOD CO 80155-3599

QUEBEC LIMITED
C/O FINLEY AND CO
12000 WASHINGTON ST NO. 100
THORNTON CO 80241

QUILLEN SARAH A
15955 JACKSON STREET
BRIGHTON CO 80602

QUINN RICKIE J AND
QUINN LINDA K
8195 E 159TH COURT
BRIGHTON CO 80602

R CHAVEZ CUSTOM HOMES INC
117 CORVETTE CT
FORT LUPTON CO 80621-7624

RAHATPURI SHAILENDRA SINGH AND
GURRAM REENA B
15143 VINE WAY
THORNTON CO 80602

RAINS RONALD J AND
RAINS CHERYL A
14081 COUNTRY HILLS DR
BRIGHTON CO 80601-6712

RAKES ERIC
15506 QUINCE CIR
THORNTON CO 80602-8508

RALL RUSS W AND
RALL DENISE R
11191 E 166TH AVENUE
BRIGHTON CO 80602

RAMIREZ JESUS GUSTAVO JR
13552 KENNEDY AVE
BRIGHTON CO 80601-6946

RANDALL ELIZABETH M
16001 RIVERDALE RD
BRIGHTON CO 80602-8304

RANDOLPH ROBERT M AND
RANDOLPH TONJA S
15885 JACKSON ST
BRIGHTON CO 80602-7795

RASMUSSEN DAVID E
8860 E 145TH PL
BRIGHTON CO 80602-5750

RAVULA SRINIVAS AND
MAHAKALA SARITHA
15117 VINE WAY
THORNTON CO 80602-7472

READY MIXED CONCRETE COMPANY
4395 WASHINGTON ST
5775 FRANKLIN ST
DENVER CO 80216-1521

REICHARD-ARMSTRONG LORI LOUIS
16197 PARIS WAY
BRIGHTON CO 80602-8297

REISBERGER TURNER AND
REISBERGER NICOLE
15180 GAYLORD ST
THORNTON CO 80602-7471

RENSHAW MARK DANIEL AND
RENSHAW AMY
13865 TRENTON ST
THORNTON CO 80602-8507

RH TODD CREEK LLC
200 W HAMPDEN AVE STE 201
ENGLEWOOD CO 80110-2407

RHEINHEIMER JOHN H AND
RHEINHEIMER SONYA E
16625 POPLAR CT
BRIGHTON CO 80602

RIBBLE MARK L AND
BAXTER KRISTINA M
13906 TAMARAC CT
THORNTON CO 80602-8443

RICHARDS SHAWN L AND
RICHARDS CHRIS A
8790 E 145TH PL
BRIGHTON CO 80602-5749

RICHMOND AMERICAN HOMES OF
COLORADO INC
4350 S MONACO ST
DENVER CO 80237-3400

RICO GARY G AND
MULLEN-RICO SHARON
15130 GAYLORD ST
THORNTON CO 80602-7471

RIO LA LLC
812 GRAVIER ST STE 360
NEW ORLEANS LA 70112-1408

RIO LA LLC
PO BOX 1231
KYLE TX 78640-1231

RITCHEY INVESTMENT COMPANY LLC
13821 SABLE BLVD
BRIGHTON CO 80601-7264

RIVERA MYSTIQUE J AND
PINTER TRAVIS
15621 QUINCE ST
THORNTON CO 80602-8174

RIVERSIDE VILLAGE OWNERS ASSOCIATION
7501 VILLAGE SQUARE DR STE 205
CASTLE PINES CO 80108-3700

ROBEY GINA
13162 PENNSYLVANIA CIR
THORNTON CO 80241-1730

ROBINETTE SHANNON AND
ROBINETTE SEAN M
10060 E 142ND AVE
BRIGHTON CO 80602-5773

ROBINSKI POLLARD INC
13950 QUEBEC ST
THORNTON CO 80602-7925

ROCHA PEDRO AND
ROCHA LETICIA
8810 E 145TH PLACE
BRIGHTON CO 80601

RODMAN LA RITA A
10821 E 155TH PL
BRIGHTON CO 80602-7443

RODRIGUEZ CHRISTOPHER JAMES AND
RODRIGUEZ SARAH JANE
13876 SPRUCE ST
THORNTON CO 80602-8456

RORVIG AARON MATTHEW AND
RORVIG SARAH DIANA
13892 TAMARAC CT
THORNTON CO 80602-8437

ROSALES JOSE AND
ROSALES NAOMI
16161 POPLAR ST
BRIGHTON CO 80602-6081

ROWZEE JACOB AND
ROBERTS LYNDSEY
15142 VINE WAY
THORNTON CO 80602

ROYBAL LANCE B
ROYBAL STEPHANIE A
7990 E 139TH AVE
THORNTON CO 80602-8138

RUSSELL GRACE
13185 BRIGHTON RD
BRIGHTON CO 80601-7341

RYAN KIM L
8631 E 163RD PL
BRIGHTON CO 80602-7572

SAATHOFF JEFFREY S AND
SAATHOFF TAMI L
14768 E 135TH AVE
BRIGHTON CO 80601

SACK ALBERT F AND
SACK ANNE V
5100 E 168TH AVE
THORNTON CO 80602

SAFI MOHAMMAD J AND
AMIN TAMANA
13916 TAMARAC CT
THORNTON CO 80602-8443

SALE RORY L AND
SALE JANE L
16247 MOLINE ST
BRIGHTON CO 80602

SALYERS CRYSTAL MICHELLE AND
SALYERS MICHAEL CHRISTOPHER
15146 VINE WAY
THORNTON CO 80602-7472

SAN MARTIN CABALLERO LLC
333 E 76TH AVE
DENVER CO 80229-6209

SANCHEZ CELESTE MAE AND
SANCHEZ ANDREW ROMAN
12101 E 160TH AVE
BRIGHTON CO 80602

SANCHEZ EDUARDO A AND
SANCHEZ DORA M
8701 E 163RD PLACE
BRIGHTON CO 80602

SANCHEZ JOHN S AND JUANITA M
11700 E 160TH AVE
BRIGHTON CO 80602

SANCHEZ ROY J AND
SHANCHEZ NICOLLE E
8457 E 163RD AVE
BRIGHTON CO 80602-7564

SASAKI FAMILY PARTNERSHIP LLLP
697 VOILES DR
BRIGHTON CO 80601-3322

SAUCEDO CLAUDIO
7199 E 163RD AVE
BRIGHTON CO 80602-7699

SAUER JOHN H
14589 E 135TH AVE
BRIGHTON CO 80601-6916

SAVE A CHILD INC
3241 W 44TH AVE
DENVER CO 80211

SCHENK RUDY AND
SCHENK LUCILLE R
8476 E 163RD AVE
BRIGHTON CO 80602

SCHISSLER JOHN
13584 CRYSTAL ST
BRIGHTON CO 80601

SCHISSLER RICKY
13544 CRYSTAL ST
BRIGHTON CO 80601-7271

SCHMIDT KYLE J
MEYERS MEGAN L
13940 TAMARAC ST
THORNTON CO 80602-8506

SCHMIDTHUBER JASON D AND
SCHMIDTHUBER AMY C
8449 E 163RD COURT
BRIGHTON CO 80602

SCHNEIDER ERICA N
8041 E 139TH AVE
THORNTON CO 80602-8139

SCHRAUBEN COREY S
13901 TAMARAC ST
THORNTON CO 80602-8506

SCHREINER DAVID L
7650 E 160TH AVE
BRIGHTON CO 80602-7536

SCHROEDER STEVEN B AND
SCHROEDER KRISTIN L
7821 E 139TH AVE
THORNTON CO 80602-8136

SCHULMAN MELVIN E AND
SCHULMAN JENNIE BRAVO
11250 E 166TH AVE
BRIGHTON CO 80602-7978

SCHULZ TODD V AND
SCHULZ JULIE J
16654 POPLAR COURT
BRIGHTON CO 80602

SCHWEITZER BROCK J AND
SCHWEITZER MANDY B
15635 HAVANA WAY
BRIGHTON CO 80602-7408

SCI - 157 LLC
1440 BLAKE ST STE 320
DENVER CO 80202-1489

SEAGROVES THOMAS ARTHUR AND GREEN ROSE IMANI
AND
ROSECHILD RENE SIMONE
15665 HAVANA WAY
BRIGHTON CO 80602-7415

SEEGER DONALD R AND
SEEGER PAULINE M
13590 SABLE BLVD
BRIGHTON CO 80601

SELTZER FARMS INC
16705 YOSEMITE ST
BRIGHTON CO 80602

SELTZER FARMS INC
9390 E 168TH AVE
BRIGHTON CO 80602-6606

SELTZER ROBERT L FAMILY TRUST
33641 COUNTY ROAD 83
BRIGGSDALE CO 80611-7808

SERRANO COURTNEY A AND
SERRANO CHRISTOPHER L
8035 E 139TH PL
THORNTON CO 80602-8145

SEYMOUR RAYMOND Z JR
13955 QUEBEC ST
BRIGHTON CO 80602-7924

SHAH VIRAL B AND
SHAH BIJALBEN
8041 E 138TH PL
THORNTON CO 80602

SHANNON JOHN T
13890 QUEBEC STREET
BRIGHTON CO 80602

SHARP AC LAND LLC
9378 S STAR HILL CIR
LONE TREE CO 80124-5443

SHEPARD STACEY AND
SHEPARD CORINNE
16171 VERBENA ST
BRIGHTON CO 80602-7552

SHEPHERD STEVEN W AND
SHEPHERD VICTORIA K
13870 QUEBEC ST
BRIGHTON CO 80602

SHERWOOD DONALD R AND
RAINS TRACY LYN
16737 LANSING CT
BRIGHTON CO 80602-7980

SHIPPY FAMILY TRUST THE
14021 COUNTRY HILLS RD
BRIGHTON CO 80601-6712

SHOUSE JOHNNY LAWRENCE AND
LAREAU DONNA MARIE
15090 GAYLORD ST
THORNTON CO 80602-7477

SHRESTHA RAJ AND
PRADHAN PRATIVA
2049 E 151ST AVE
THORNTON CO 80602-7475

SICHTING ZERRI J AND
SICHTING MELLISA C
16071 POPLAR STREET
BRIGHTON CO 80602

SJOLIN CRAIG AND
SJOLIN CHRISTINA
7128 E 163RD AVE
BRIGHTON CO 80602-7698

SKINNER JESSICA A
15511 QUINCE CIR
THORNTON CO 80602-8508

SKOREV ANDREY AND
SKOREV KRISTINA
11150 E 163RD CT
BRIGHTON CO 80602-7569

SMITH JOHNNY WAYNE AND
SMITH CANDACE R
15561 SYRACUSE WAY
THORNTON CO 80602-8171

SMITH TIMOTHY R AND
SMITH CARMEN M
7937 E 139TH PL
THORNTON CO 80602-8143

SNOOK DON R AND SNOOK SUSAN B
10370 E 142ND AVE
THORNTON CO 80602-5774

SOLANO GREGORY ALLEN AND
CALEGAN SOLANO KAREN ANNE
8040 E 139TH AVE
THORNTON CO 80602-8139

SPARROW JEFFERY C AND
SPARROW RUTHANN
8720 E 163RD PL
BRIGHTON CO 80602-7584

SPERRY NATHANIEL M AND
SPERRY ADRIENNE R
16201 VERBENA ST
BRIGHTON CO 80602-7553

SPURGEON LIVING TRUST
16032 OLIVE ST
BRIGHTON CO 80602-6002

STADLER RYAN L AND
STADLER SHEILA L
16272 POPLAR ST
BRIGHTON CO 80602-6076

STANLEY GARY M AND
STANLEY LORRAINE J
8028 E 139TH PL
THORNTON CO 80602-8145

STANLEY JOSHUA T
7908 E 139TH PL
THORNTON CO 80602-8143

STANLEY RUPERT H AND
STANLEY DEBORAH L
16232 POPLAR ST
BRIGHTON CO 80602-6076

STARK BRIAN AND
STARK SARAH
7126 E 162ND CT
BRIGHTON CO 80602-8065

STEEGER CHRISTOPHER JOHN AND
STEEGER CHRISTINE MARIE
15123 VINE WAY
THORNTON CO 80602-7472

STELLJES NICOLLE MARIE AND
STELLJES VON DEWAYNE JR
15625 RIVERDALE RD
BRIGHTON CO 80602-8216

STEPHENS LINDY LOU
1076 S 935 RD
EL DORADO SPRINGS MO 64744-7279

STEVENS DOMINIC ALDEN
7828 E 139TH PL
THORNTON CO 80602-8141

STEVENS MICHAEL C AND
STEVENS TAMMARA
16282 POPLAR ST
BRIGHTON CO 80602-6076

STIMMEL CHRISTOPHER J AND
MCGINNESS MELISSA R
6051 E 160TH PLACE
BRIGHTON CO 80602

STINSON CHRISTOPHER LYN AND
STINSON ASHLEY ANNE
16300 PARIS WAY
BRIGHTON CO 80602-8298

STONEHOCKER ROSWITHA M
15600 HOLLY ST
BRIGHTON CO 80602-7911

STRAIGHT PATH LLC
8181 E 136TH AVE
BRIGHTON CO 80602-8112

STRAIN CONNIE J AND
CLAYTON KERRIE R
8031 E 138TH PL
THORNTON CO 80602-8133

STRATUS TALON VIEW LLC
8480 E ORCHARD RD STE 1100
GREENWOOD VILLAGE CO 80111-5015

STREET JERALD R AND
STREET BARBARA R
13541 SABLE BLVD
BRIGHTON CO 80601

STRUCK BRENT ALAN
2059 E 151ST AVE
THORNTON CO 80602-7475

STUMBAUGH BRYAN
7162 EAGLE SHADOW AVE
BRIGHTON CO 80602-6000

SULLIVAN MICHAEL JOHN AND
SULLIVAN SANDRA LEE
15573 SYRACUSE WAY
THORNTON CO 80602-8171

SUNDER CECIL
15171 GAYLORD ST
THORNTON CO 80602-7471

SW BIG CIRCLE RANCH LLC
5600 S QUEBEC ST STE 110A
GREENWOOD VILLAGE CO 80111-2205

SWANTKOSKI JAROD AND
SWANTKOSKI ANGELA
16080 IVANHOE ST
BRIGHTON CO 80602

TACEY HOLLEE ANN AND
TACEY ERIC JOSEPH
8018 E 139TH PL
THORNTON CO 80602-8145

TALLEY MICHAEL DALE AND
TALLEY DALE
8025 E 139TH PL
THORNTON CO 80602-8145

TALON POINTE LAND LLC
1610 WYNKOOP ST STE 500
DENVER CO 80202-1158

TALON POINTE METROPOLITAN DISTRICT
10450 E 159TH CT
BRIGHTON CO 80602-7977

TASHIRO STUART AND
TASHIRO MICHELLE
13393 BRIGHTON RD
BRIGHTON CO 80601

TATRO JAMES A AND
TATRO DENISE A
11323 E 167TH AVE
BRIGHTON CO 80602-7979

TAYLOR TAYLOR PAIGE AND
TAYLOR JAMES E
15543 QUINCE ST
THORNTON CO 80602-8170

TENOR TENZIN
15519 QUINCE CIR
THORNTON CO

THAMMASINE SONEPRASEUTH AND
VILAYHONG NUDDA
2188 E 151ST AVE
THORNTON CO 80602-7476

THF PRAIRIE CENTER DEVELOPMENT LLC
C/O THF REALTY INC
211 N STADIUM BLVD STE 201
COLUMBIA MO 65203-1161

THOMAS JAMES R
13581 SABLE BLVD
BRIGHTON CO 80601-7266

THOMAS JOSEPH JEFFREY AND
THOMAS KIM TERES
15930 JACKSON STREET
BRIGHTON CO 80602

THOMPSON STEVEN P
5853 E 161ST AVE
BRIGHTON CO 80602-7964

THORNGREN CYNTHIA L
12980 E 136TH AVE
BRIGHTON CO 80601-7281

THORPE REX L AND
THORPE C JANE
16284 WILLOW STREET
BRIGHTON CO 80602

TIESSEN DAN E AND
TIESSEN SHELLEY A
15513 QUINCE CIR
THORNTON CO 80602

TODD CREEK FARMS METRO DIST NO 1 WATER
C/O ZIONS FIRST NATIONAL BANK TRUSTEE
717 17TH ST STE 301
DENVER CO 80202-3310

TODD CREEK MEADOWS OWNERS
ASSOCIATION INC
8700 TURNPIKE DR STE 230
WESTMINSTER CO 80031-4301

TODD CREEK VILLAGE
METROPOLITAN DISTRICT
10450 E 159TH CT
BRIGHTON CO 80602-7977

TODD CREEK VILLAGE METROPOLITAN
DISTRICT
10450 E 159TH CT
BRIGHTON CO 80602-7977

TODD CREEK VILLAGE METROPOLITAN
DISTRICT
10450 E 159TH CT
BRIGHTON CO 80602

TODD CREEK VILLAGE PARK
AND RECREATION DISTRICT
2100 S LINCOLN ST STE 2000
DENVER CO 80210-4409

TODD CREEK VILLAGE PARK
AND RECREATION DISTRICT
1700 N LINCOLN ST STE 2000
DENVER CO 80203-4554

TODD CREEK VILLAGE PARK AND
RECREATION DISTRICT
1700 N LINCOLN ST STE 2000
DENVER CO 80203-4554

TODD CREEK VILLAGE PARK AND RECREATION
DIST C/O MURRAY DAHL KUECHENMEISTER AND
1700 LINCOLN ST STE 3800
DENVER CO 80203-4538

TORRES MARIA S
TORRES EVERARDO L
15101 GAYLORD ST
THORNTON CO 80602-7471

TROSTEL JUSTIN
9065 E 139TH CT
BRIGHTON CO 80602-8207

TROSTEL MITCHELL RHONDA AND
MITCHELL ROBERT
PO BOX 1614
GILLETTE WY 82717-1614

TRUJILLO RICHARD L AND
SANCHEZ STEPHANIE
8015 E 139TH PL
THORNTON CO 80602-8145

TRUJILLO STEVEN M AND
TRUJILLO MARYBELL C
9115 E 139TH COURT
BRIGHTON CO 80602

TUCCIO JOHN N JR AND
TUCCIO YONG S
15151 GAYLORD ST
THORNTON CO 80602

TUCKER JAMES A
TUCKER MARGARET D
13890 TAMARAC CT
THORNTON CO 80602-8437

UHING KENNETH D
13526 KENNEDY AVE
BRIGHTON CO 80601-6946

UNITED POWER INC
ATTN: PROPERTY TAX DEPT.
BRIGHTON CO 80603-8728

VELEZ RAFAEL A AND
VELEZ JEAN MARIE
7878 E 139TH PL
THORNTON CO 80602-8141

VENKATARAMAN BALAJI RANGANATHAN AND
BALAJI LAVANYA
15170 GAYLORD ST
THORNTON CO 80602-7471

VILLENEUVE PAULINE
1250 S MONACO PKWY APT 76
DENVER CO 80224-1876

VIRGIL RICHARD DANIEL
11505 E 162ND DR
BRIGHTON CO 80602-7684

VO THANH AND
VO JUDY
11360 E 163RD CT
BRIGHTON CO 80602-7578

VOHL MATTHEW
16274 PARIS WAY
BRIGHTON CO 80602-8299

VOLKMAN CHISTOPHER J
13896 TAMARAC ST
THORNTON CO 80602-8474

VUE JAY M AND
VUE MARIA CRISTINA G
10130 E 142ND AVE
BRIGHTON CO 80602-5773

W AND D MC DONALD TRUST
16055 IVANHOE ST
BRIGHTON CO 80602-7981

WAGNER BERNARD TRUST 1/2 INT AND
MAYHEW PHYLLIS K TRUST 1/2 INT
14801 E 144TH AVE
BRIGHTON CO 80601-6748

WAGNER HOWARD F
15543 QUINCE CIR
THORNTON CO 80602-8508

WAGNER KIMBERLY D
9900 E 138TH PL
BRIGHTON CO 80602-8213

WAGNER RICK LYNN/GARY RON AND
WAGNER TERRY DON
8808 BEHRENS MILE ROAD
BYERS CO 80103

WALTER ERIC C AND
WALTER KATHERINE A
16135 IVANHOE ST
BRIGHTON CO 80602-7982

WANDZEK MICHAEL C AND
WANDZEK SATHYA F
16292 POPLAR ST
BRIGHTON CO 80602-6076

WARRINGTON RICHARD R
8201 E 160TH AVENUE
BRIGHTON CO 80602

WASTART BRANDON J AND
WASTART KRISTEN E
7948 E 139TH PL
THORNTON CO 80602-8143

WATERMAN JEFFREY ELDON AND
LOWERY-WATERMAN TRISTA RENE
2128 E 151ST AVE
THORNTON CO 80602-7476

WATKINS BILLY J
16300 YOSEMITE ST
BRIGHTON CO 80602

WEBB GEORGE F
14600 E 136TH AVE
BRIGHTON CO 80601-6948

WEBB PHYLLIS ELLEN TRUST THE
12152 E 168TH AVE
BRIGHTON CO 80602-6661

WEBER TIMOTHY D AND
WEBER SHARON A
9865 E 138TH PLACE
THORNTON CO 80602

WEEKS-CARD ROBIN DANIELLE AND
CARD DANIEL K
16780 LANSING CT
BRIGHTON CO 80602-7980

WEIGEL EDWARD AND
WEIGEL SHARON K
13990 BOSTON ST
BRIGHTON CO 80602

WEINKAUF JOSHUA J AND
WIENKAUF KAARI A
11103 E 163RD CT
BRIGHTON CO 80602

WEINMASTER BRIAN F AND
WEINMASTER MARIE
16720 MT WILSON CT
BRIGHTON CO 80602

WEINS JOHN AND
WEINS LINDA
312 MESA ST
BRIGHTON CO 80601-4178

WELHAM BLAZE G/REBECCA A AND
WELHAM ROD G/JEANNE L
13970 DEXTER ST
THORNTON CO 80602-7034

WERBACH CYNTHIA
16601 E 136TH AVE
BRIGHTON CO 80601-6956

WEST ORREN JR AND
WEST KRISTINE
7208 EAGLE SHADOW AVE
BRIGHTON CO 80602-6000

WEWEL PAUL A AND
WEWEL DIANNA F
1187 MC INTOSH AVE
BROOMFIELD CO 80020

WHATTON TREVOR JOSIAH AND
WOODS VICTORIA L
15520 QUINCE CIR
THORNTON CO 80602-8508

WHITE JAMES R AND MARY D
13880 QUEBEC ST
BRIGHTON CO 80602

WHITE LARRY A AND
WHITE DIANE C
14050 COUNTRY HILLS DR
BRIGHTON CO 80601

WHITE WESLEY A
15113 VINE WAY
THORNTON CO 80602-7472

WHITT ERIC AND
WHITT DIANE
16260 NOME ST
BRIGHTON CO 80602-8301

WILDMAN KELLI LYN AND
WILDMAN KAREN ELAINE
15132 VINE WAY
THORNTON CO 80602-7472

WILSON RANDALL AND
RAPP CYNTHIA
11177 E 162ND PL
BRIGHTON CO 80602-8257

WINE LEWIS L AND
WINE HEATHER C
5862 E 161ST AVE
BRIGHTON CO 80602

WINSLOW RICHARD S AND
WINSLOW MICHELE R
16015 OLIVE ST
BRIGHTON CO 80602-6002

WINTERS LAURIE A
15651 MONACO ST
BRIGHTON CO 80602

WISDOM STEPHEN AND
WISDOM WHITNEY
7887 E 139TH PL
THORNTON CO 80602-8141

WISE EDWARD L JR AND
WISE JUDITH M
11120 E 166TH AVE
BRIGHTON CO 80602-6614

WISE GERALD AND WISE BONNIE
PO BOX 956
BRIGHTON CO 80601-0956

WISOTZKEY RICHARD J AND
GREFRATH LISA H
16045 OLIVE ST
BRIGHTON CO 80602

WOLFE TODD D
WOLFE LAURA
16291 VERBENA ST
BRIGHTON CO 80602-7553

WONG RANDALL E AND
GARRIS DIANA L
2069 E 151ST AVE
THORNTON CO 80602-7475

WOOD JERRY D
11880 E 160TH AVE
BRIGHTON CO 80602-7437

WOOD MICHAEL R AND
WOOD KRISTI L
11097 E 162ND PL
BRIGHTON CO 80602-8256

WRAY GEORGE H AND
WRAY JEANNETTE I
13564 CRYSTAL STREET
BRIGHTON CO 80601

WRIGHT REVA L
PO BOX 274
BRIGHTON CO 80601-0274

XU JINGHANG
8300 E 145TH PL
THORNTON CO 80602-5766

XU WEN YING AND PHU ANITA AND
PHU COONG VAY
16360 PARIS WAY
BRIGHTON CO 80602-8298

YORE MICHAEL AND
YORE MARILYN GUYTON
11163 E 163RD CT
BRIGHTON CO 80602-7569

YOUMANS ARDEN A AND
YOUMANS BARBARA S
14708 E 135TH AVENUE
BRIGHTON CO 80601

ZAMORA MANUEL J AND
ZAMORA MARJORIE
15440 JOLIET CT
BRIGHTON CO 80602-7447

ZANGANEH ALI
16095 OLIVE ST
BRIGHTON CO 80602-6002

ZELLER BENJAMIN CAMPS AND
ZELLER AMBER NICOLE
15133 VINE WAY
THORNTON CO 80602-7472

ZEMLICKA JASON AND
ZEMLICKA REBECCA
11143 E 163RD CT
BRIGHTON CO 80602-7569

ZHANG SONG AND XU YILI
16773 POPLAR CT
BRIGHTON CO 80602

ZIMMERMAN CARRIE L AND
ZIMMERMAN GREGORY W
13516 KENNEDY AVE
BRIGHTON CO 80601-6946

ZNIDARCIC LUKA AND
ZNIDARCIC JENNIFER JAN
15137 VINE WAY
THORNTON CO 80602

CERTIFICATE OF POSTING

I, J. Gregory Barnes do hereby certify that I posted the subject property on July 28, 2020, in accordance with the requirements of the Adams County Development Standards and Regulations.

J. Gregory Barnes

Pioneer Produced Water Pipeline Project

RCU2020-00004

September 1, 2020

Board of County Commissioners Public Hearing

Community and Economic Development Department

Case Manager: Greg Barnes

Requests

- Conditional Use Permit to construct a new pipeline system conveying produced water

- Development Agreement that covers pre-construction requirements, construction and operational standards, and maintenance.

Background

- Can connect to 16 regional well pads
- Transports Produced Water
- Destination: Expedition Water Solutions #6 Wastewater Injection and Disposal facility in Weld County
- Pipeline Length:
  - Overall : 48.5 miles
  - Adams County: 19 miles
    - Unincorporated: 12 miles (42 properties)
    - Brighton/Thornton: 7 miles
- 4-12 inches in diameter
- Reduction of an estimated 5,000,000 truck miles and over 50,000 truckloads per year on local roads

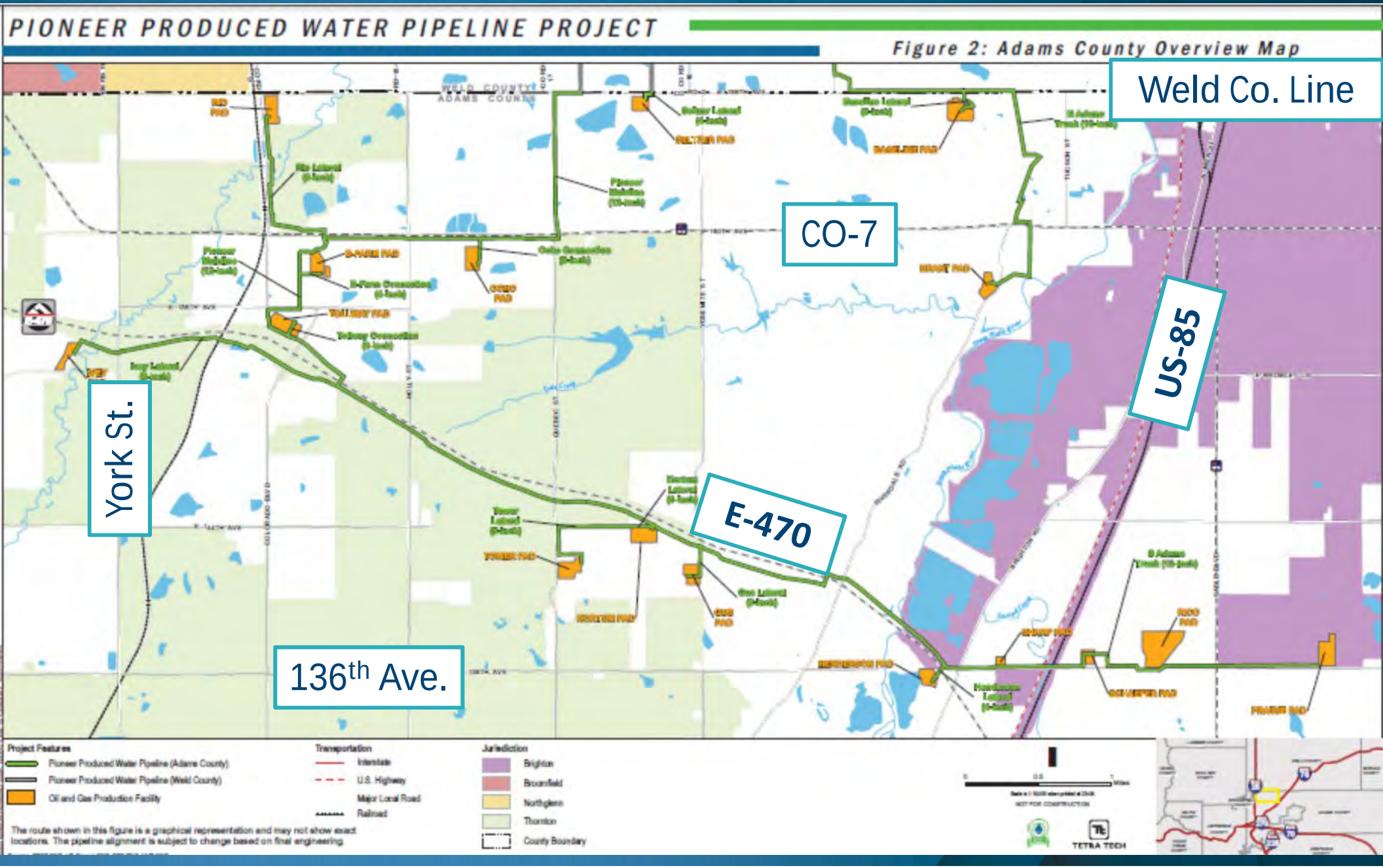
Background

Table 3:

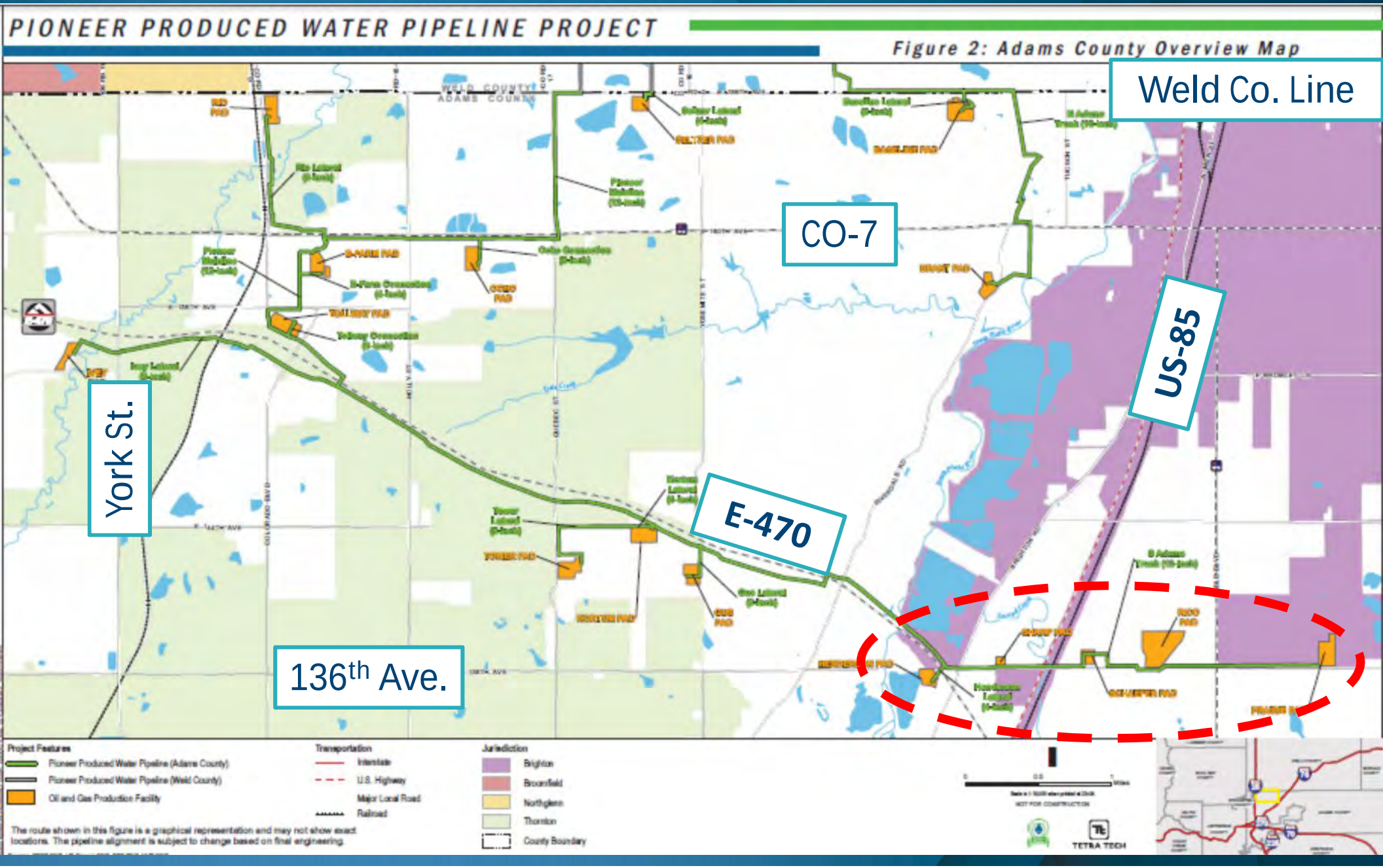
Oil and Gas Production Facility Permitting Jurisdictions and Permitting Status

Oil and Gas Production Facility Name	Permitting Jurisdiction	Permit Number/Status
Baseline	Adams County	USR2018-00010
B-Farm	Adams County	USR2017-00004
Brant	Adams County	USR2018-00011
Gus	Adams County	USR2018-00013
Ivey	Adams County	USR2016-00006
Kortum	Adams County	USR2018-00009
Ocho	Adams County	USR2016-00005
Rio	Adams County	USR2019-00001
Schaefer	Adams County	USR2016-00003
Seltzer	Adams County	USR2018-00002
Tollway	Adams County	USR2018-00005
Tower	Adams County	USR2018-00012
Sharp	Adams County	Application for USR in progress
Rico	Adams County	Application for USR in progress
Henderson	Adams County	Application for USR in progress
Prairie	Brighton	Located within the City of Brighton (Case File 18-00214)

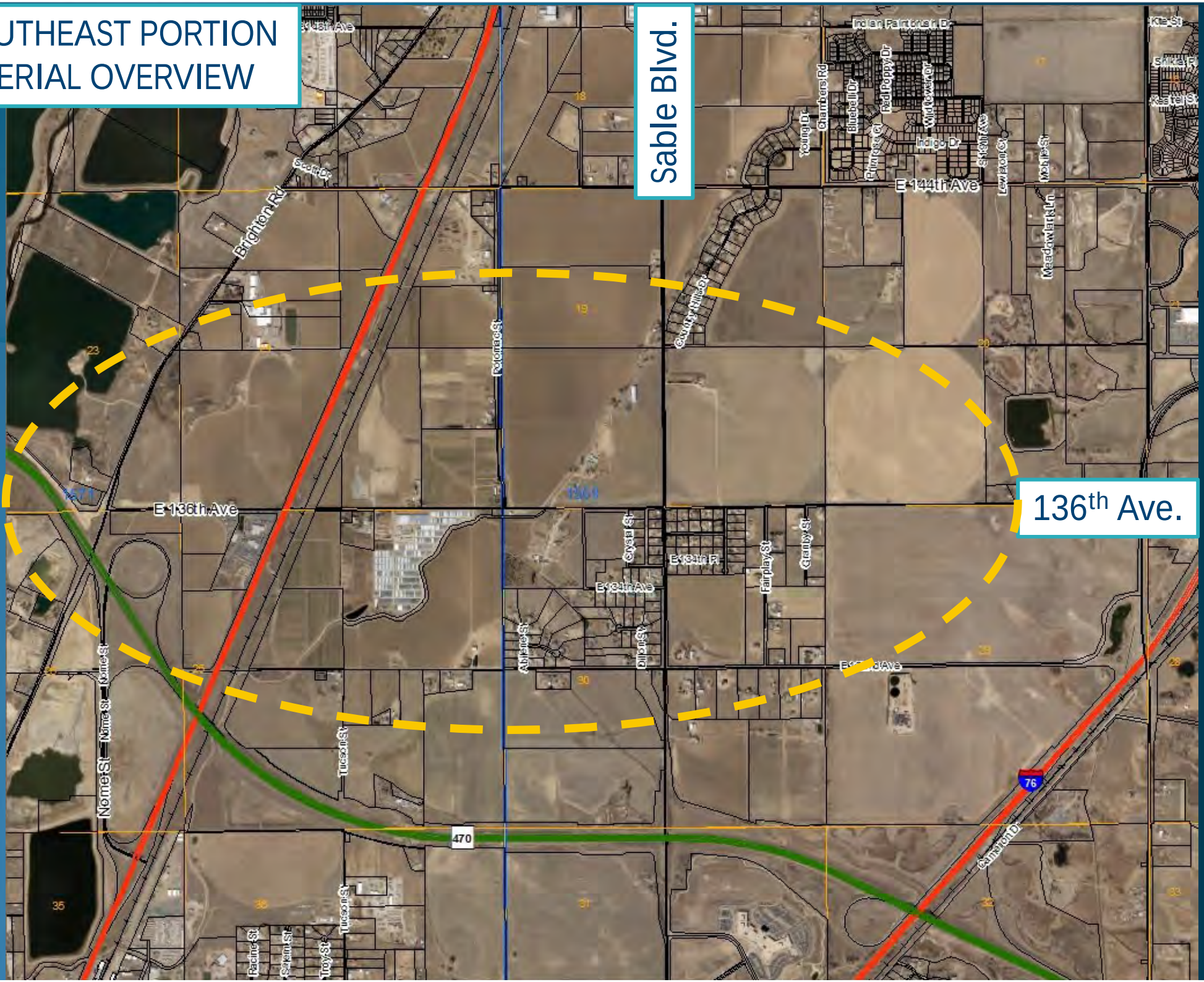
PIPELINE LOCATION OVERVIEW



PIPELINE LOCATION OVERVIEW



SOUTHEAST PORTION AERIAL OVERVIEW



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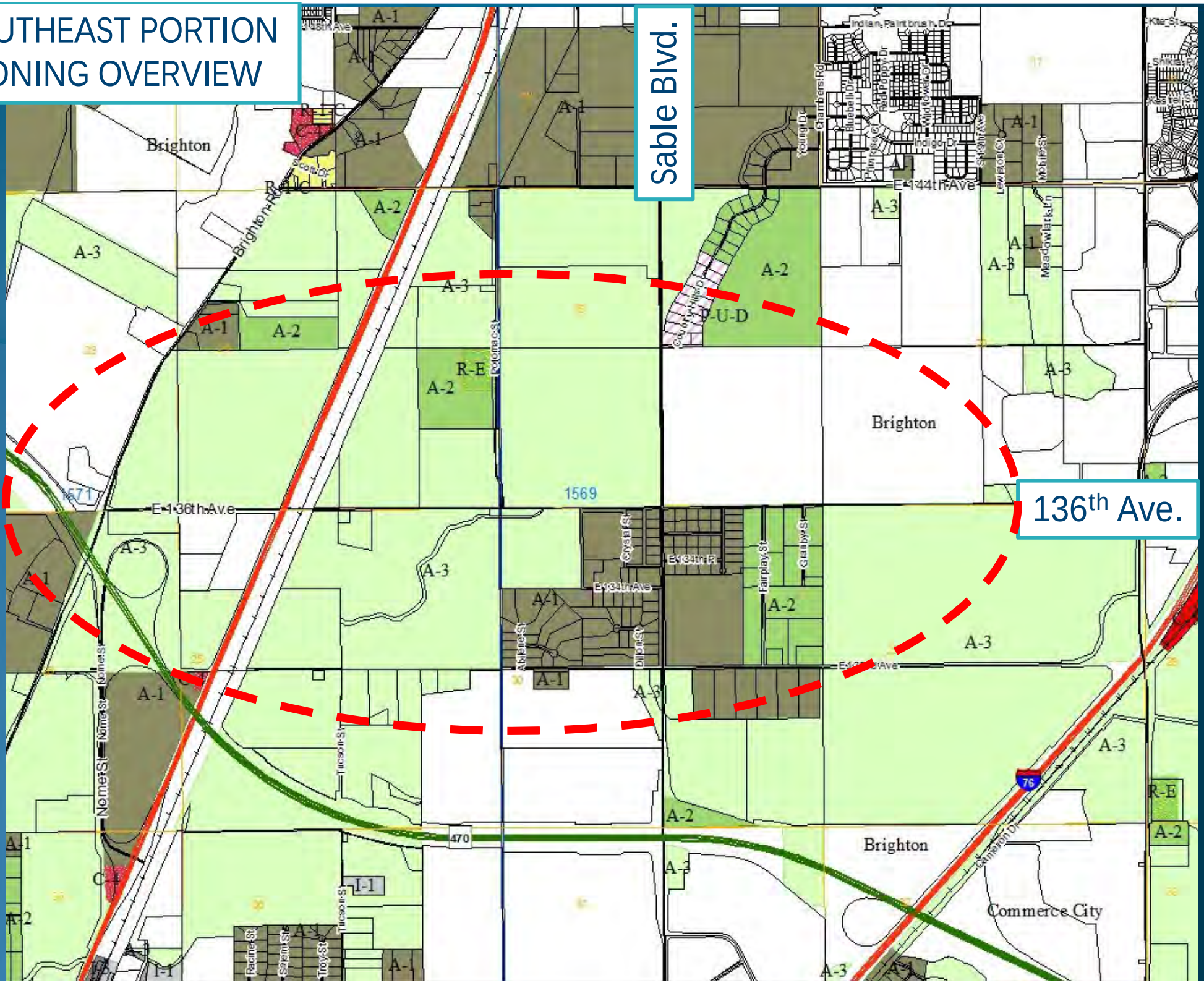

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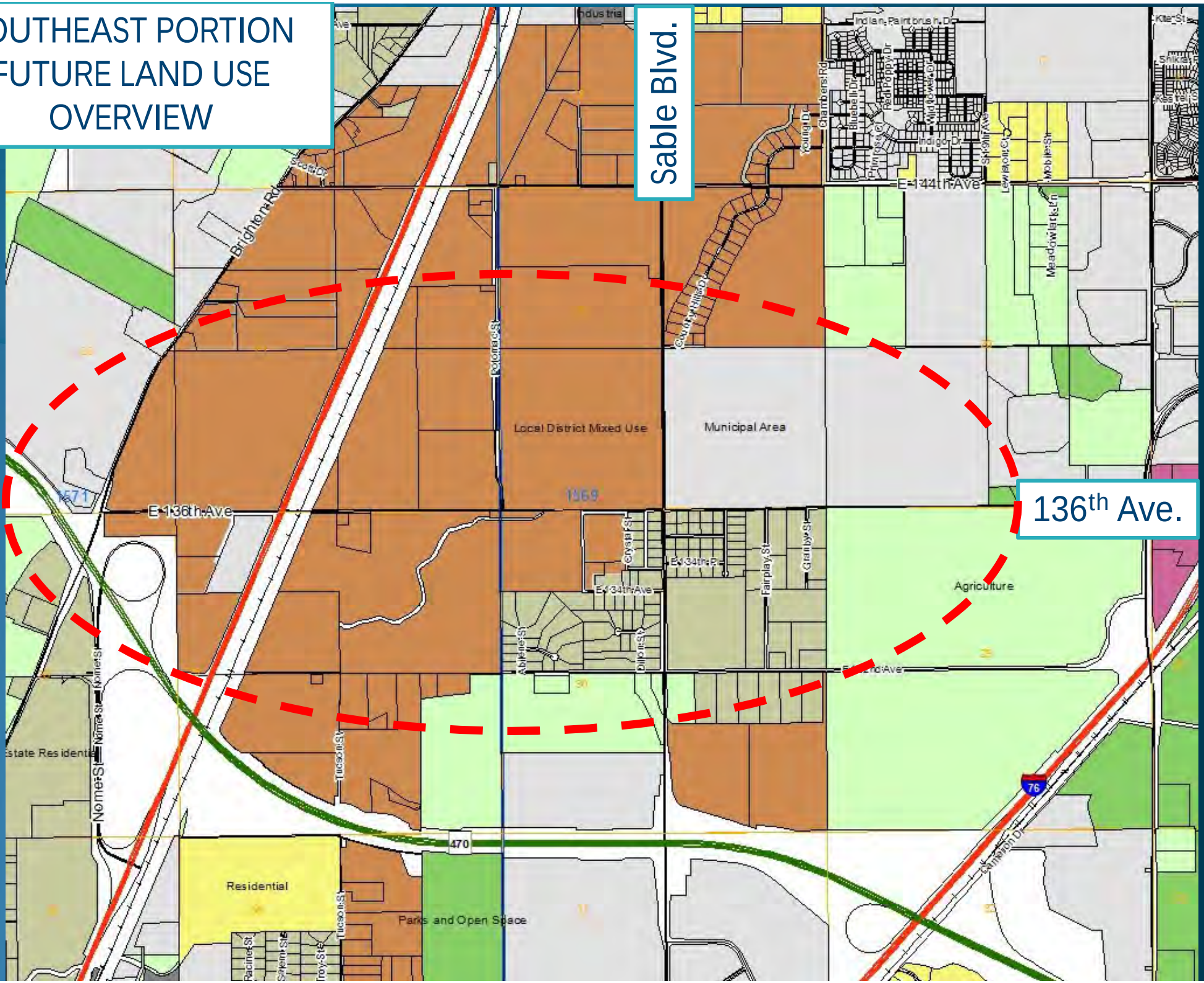
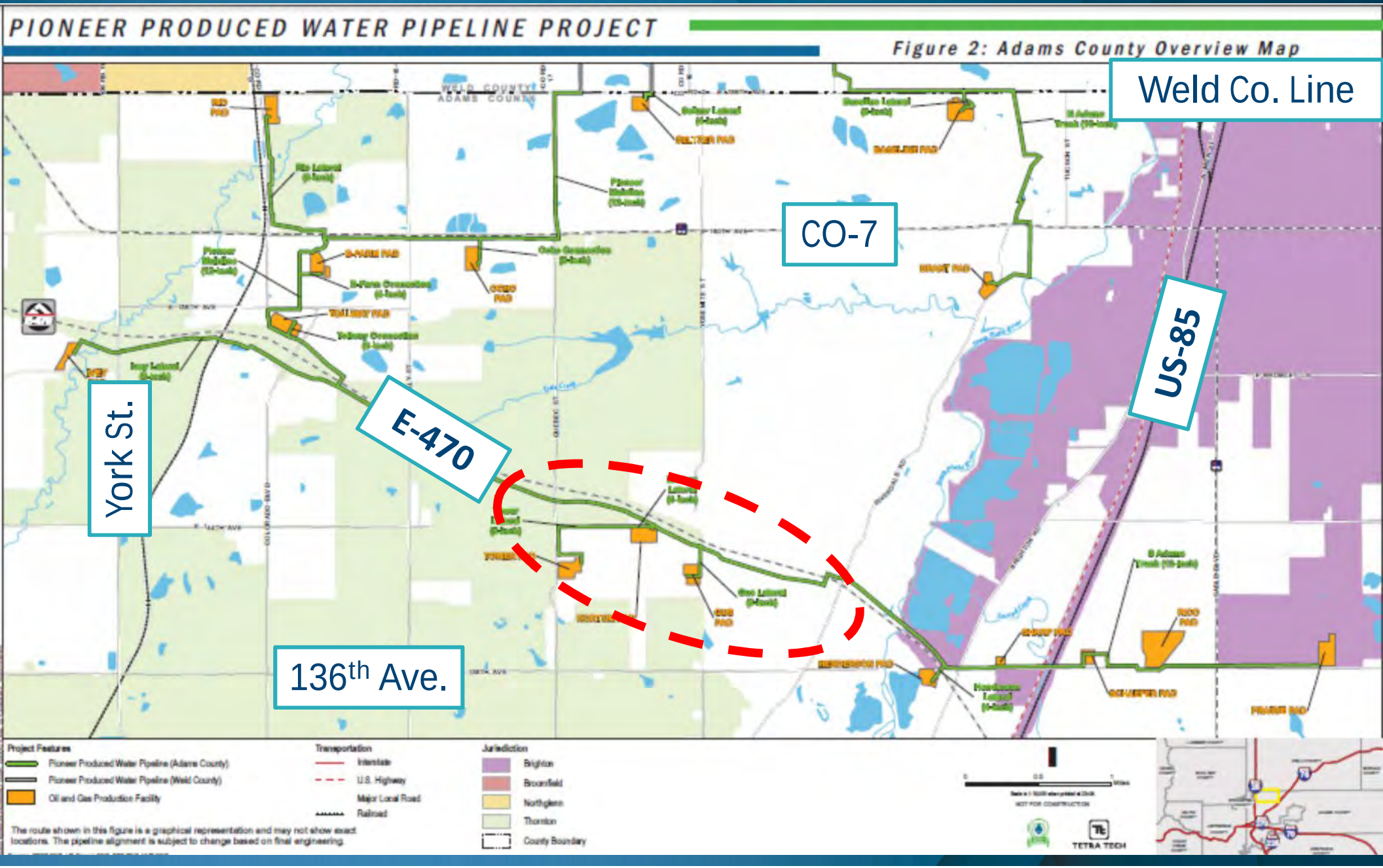


PIPELINE LOCATION OVERVIEW



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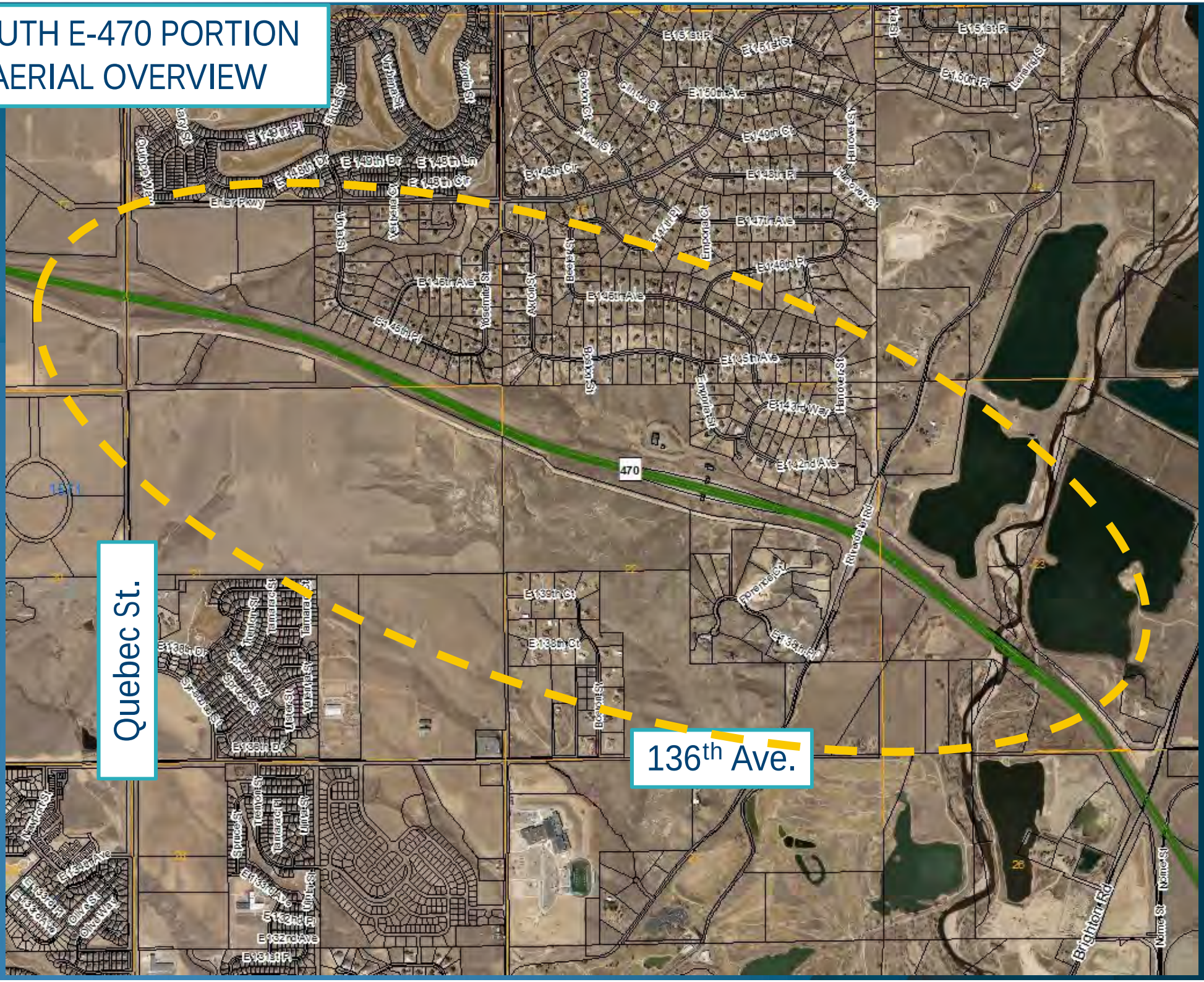

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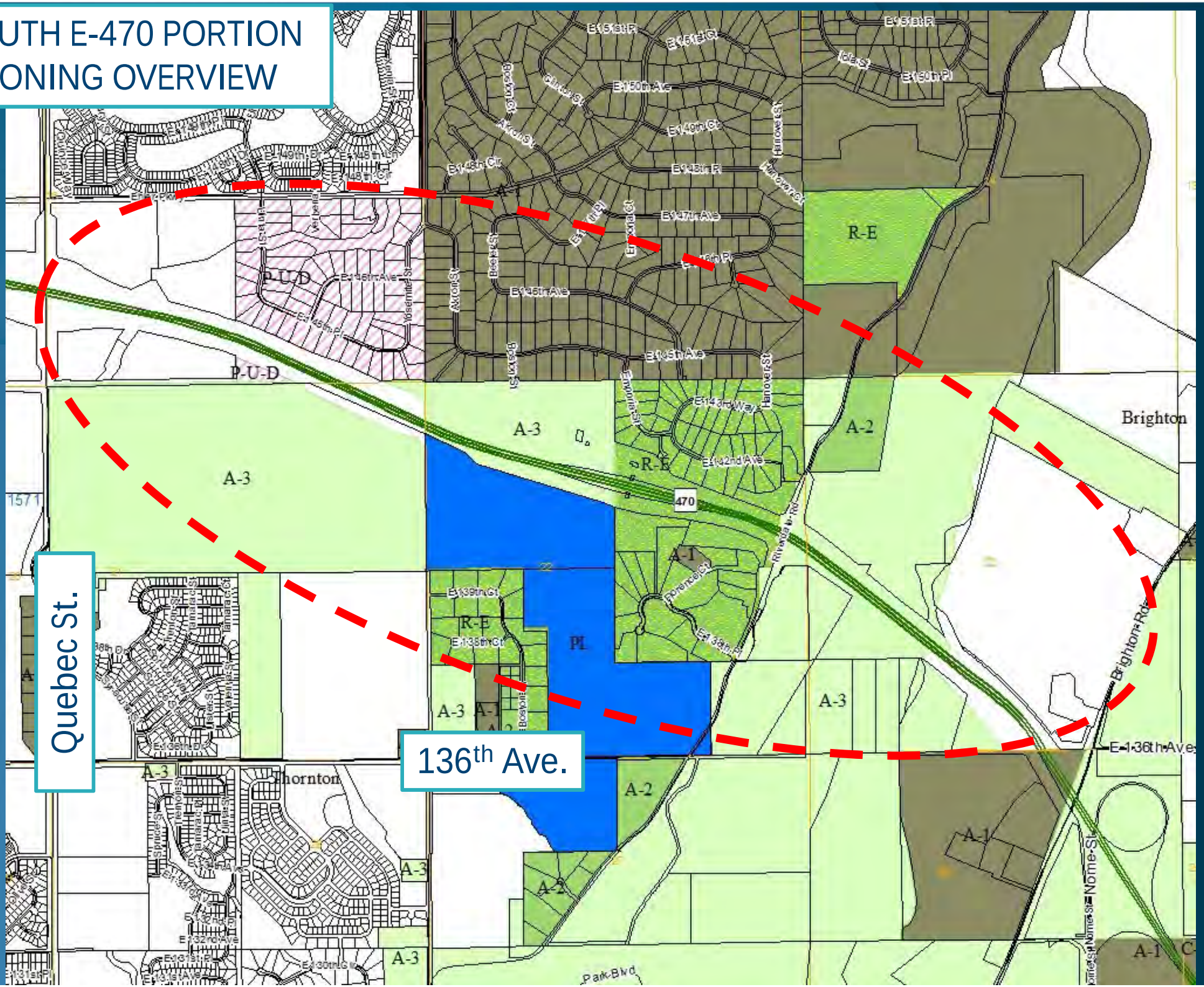

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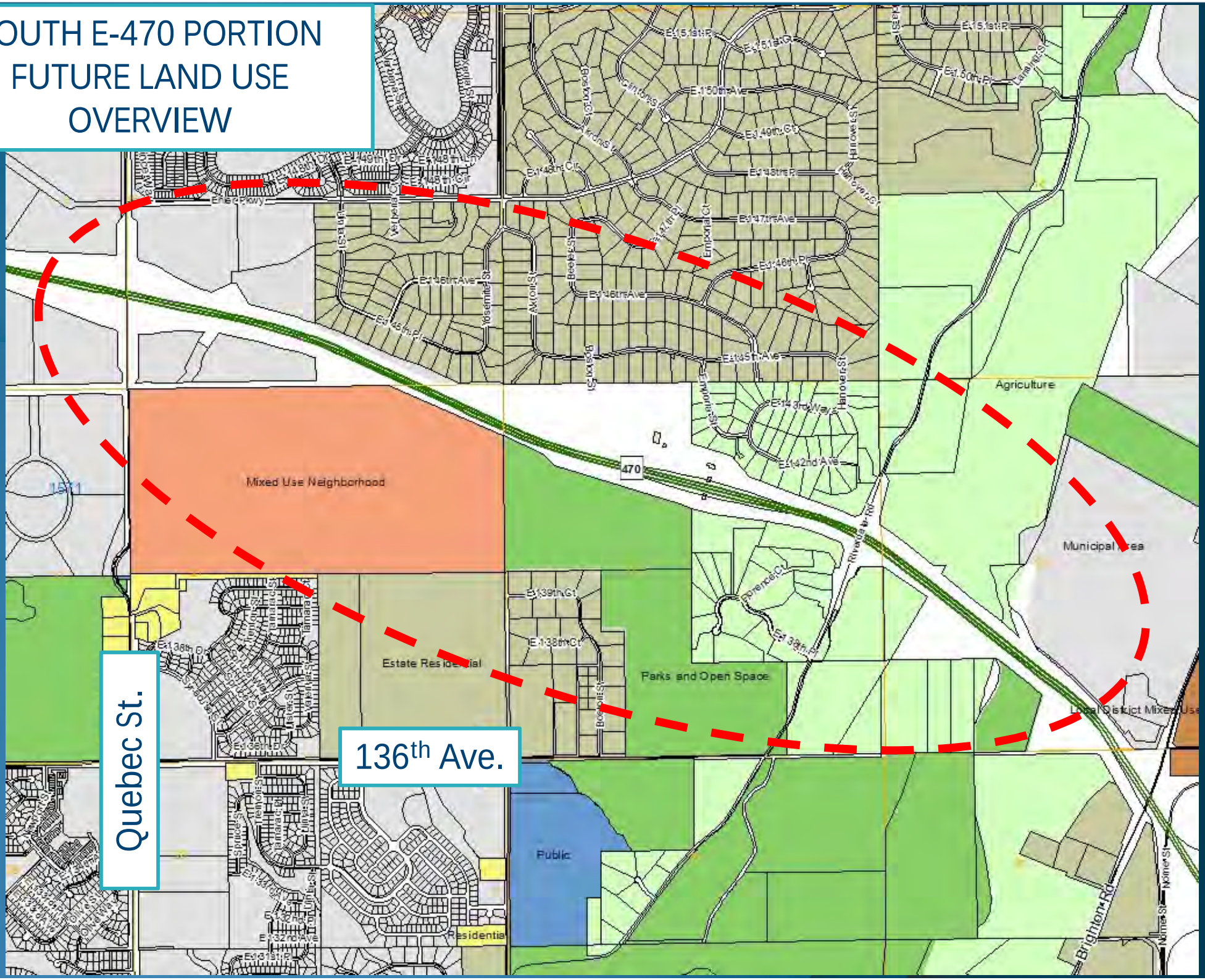

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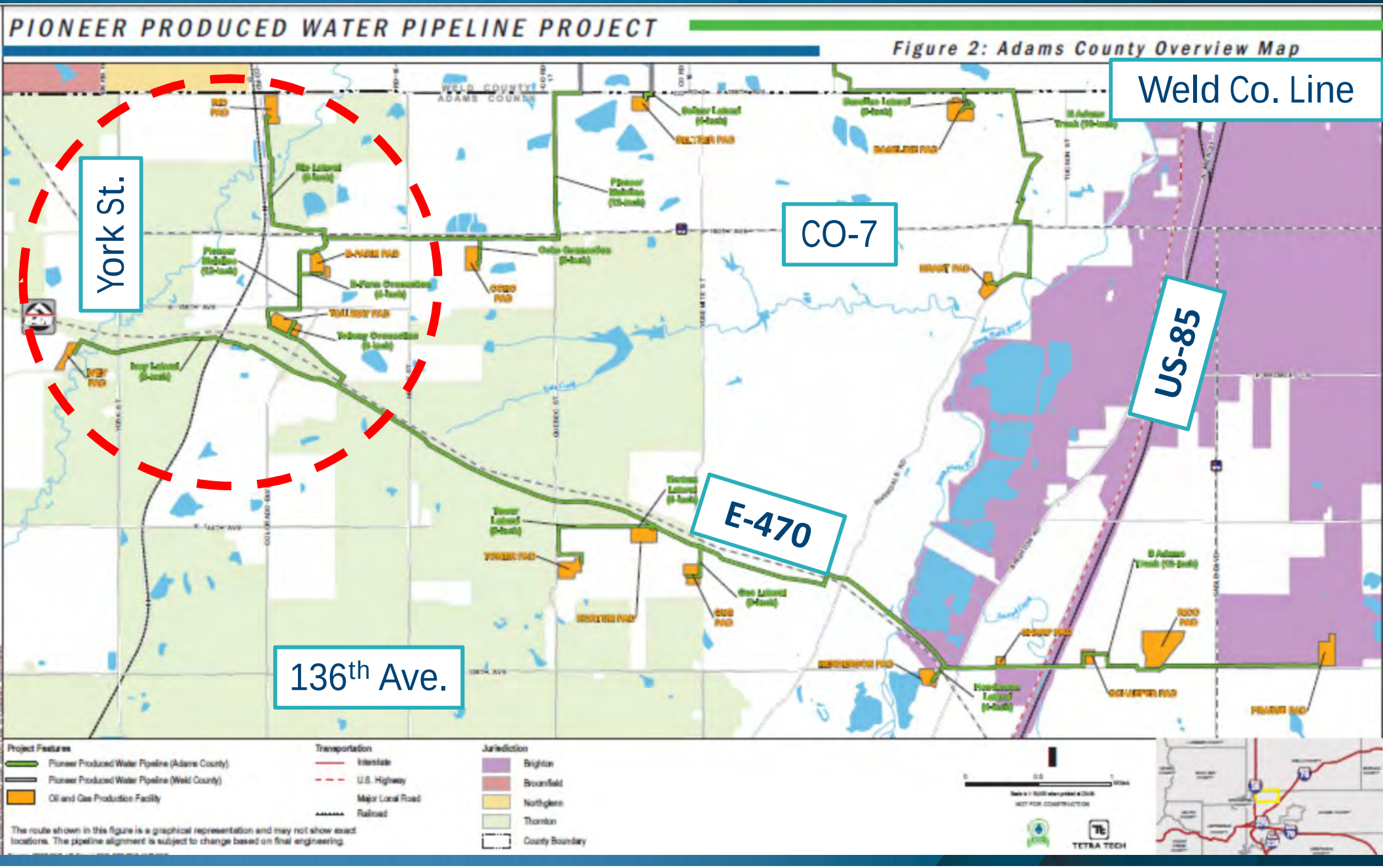

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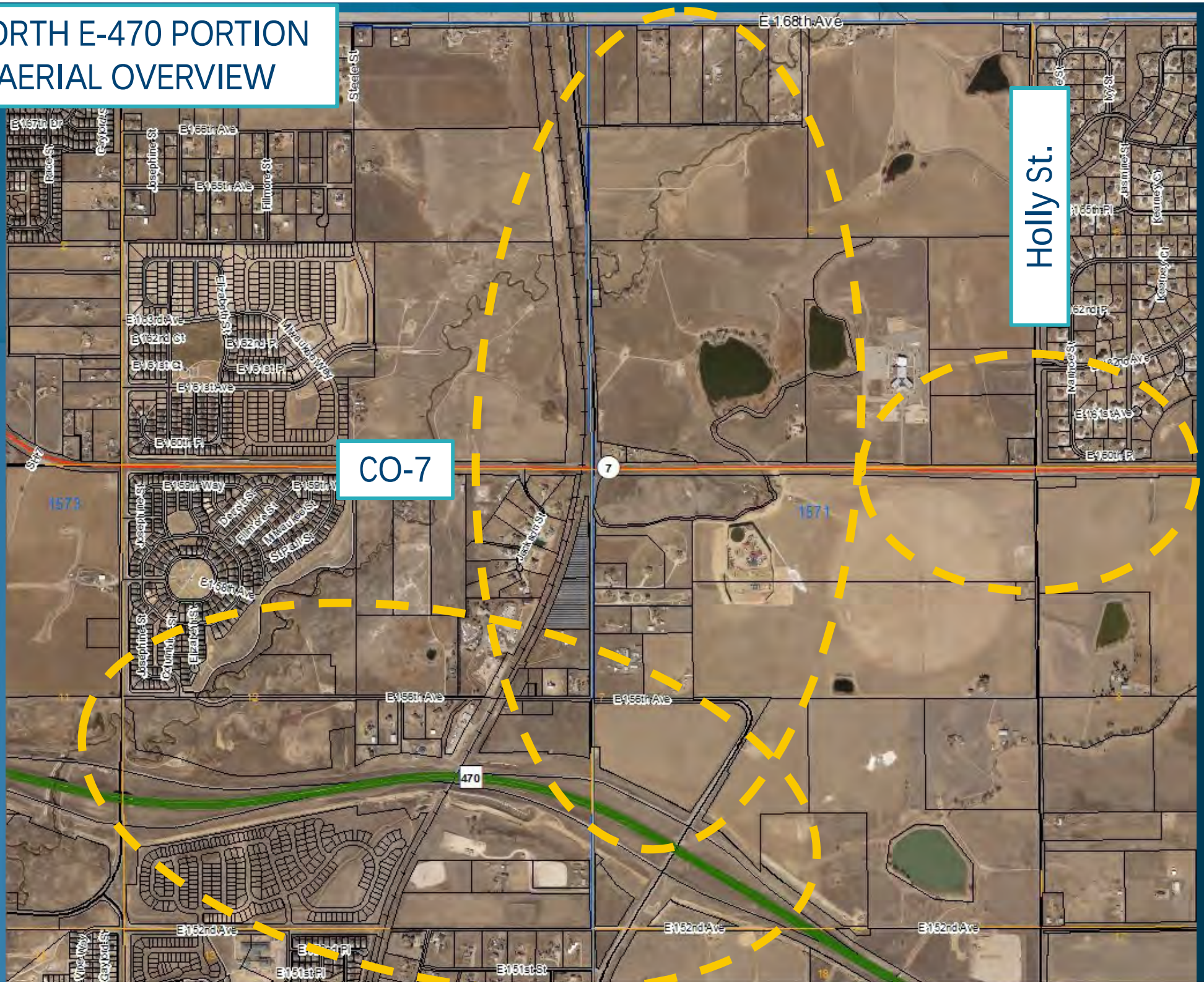

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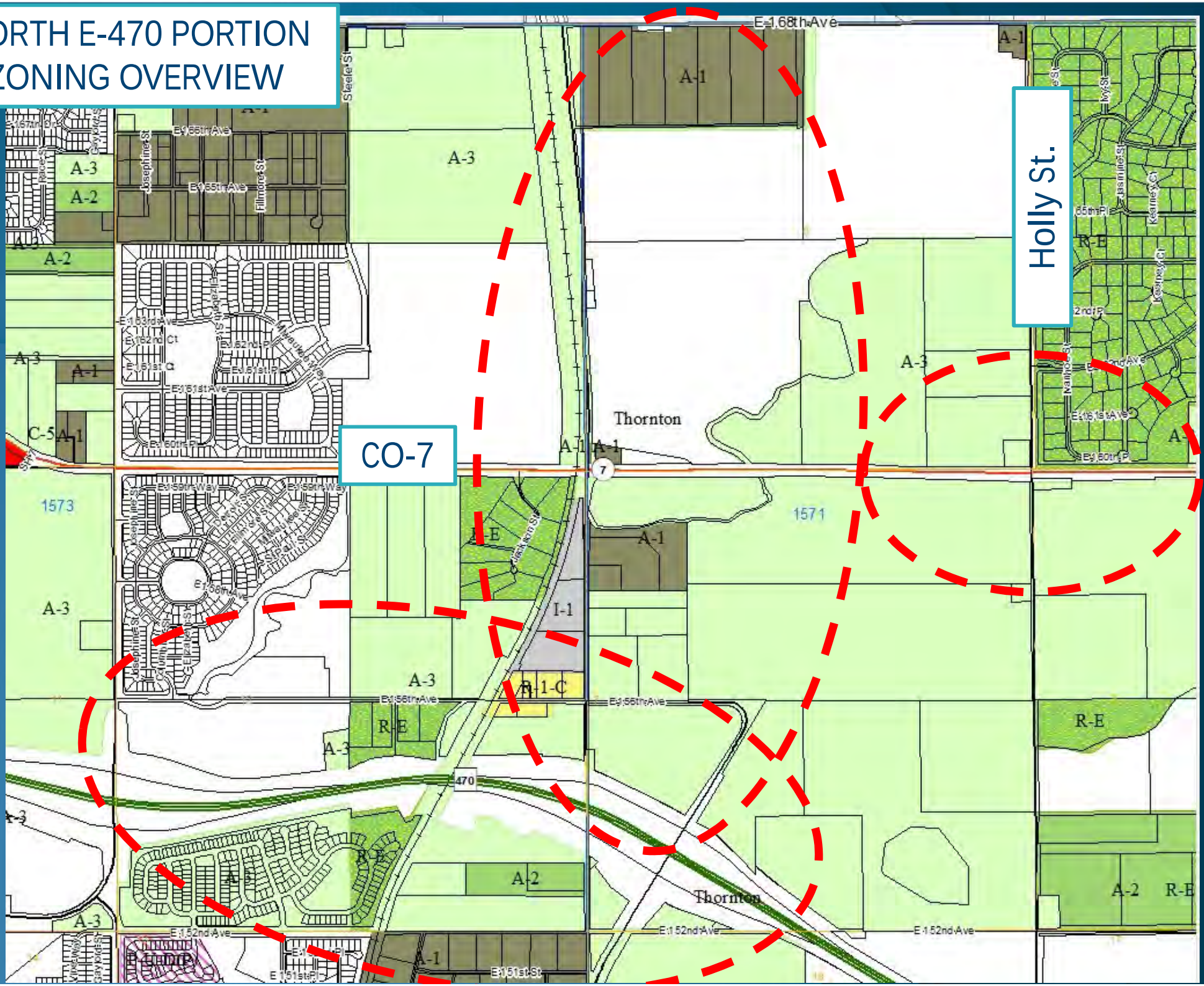

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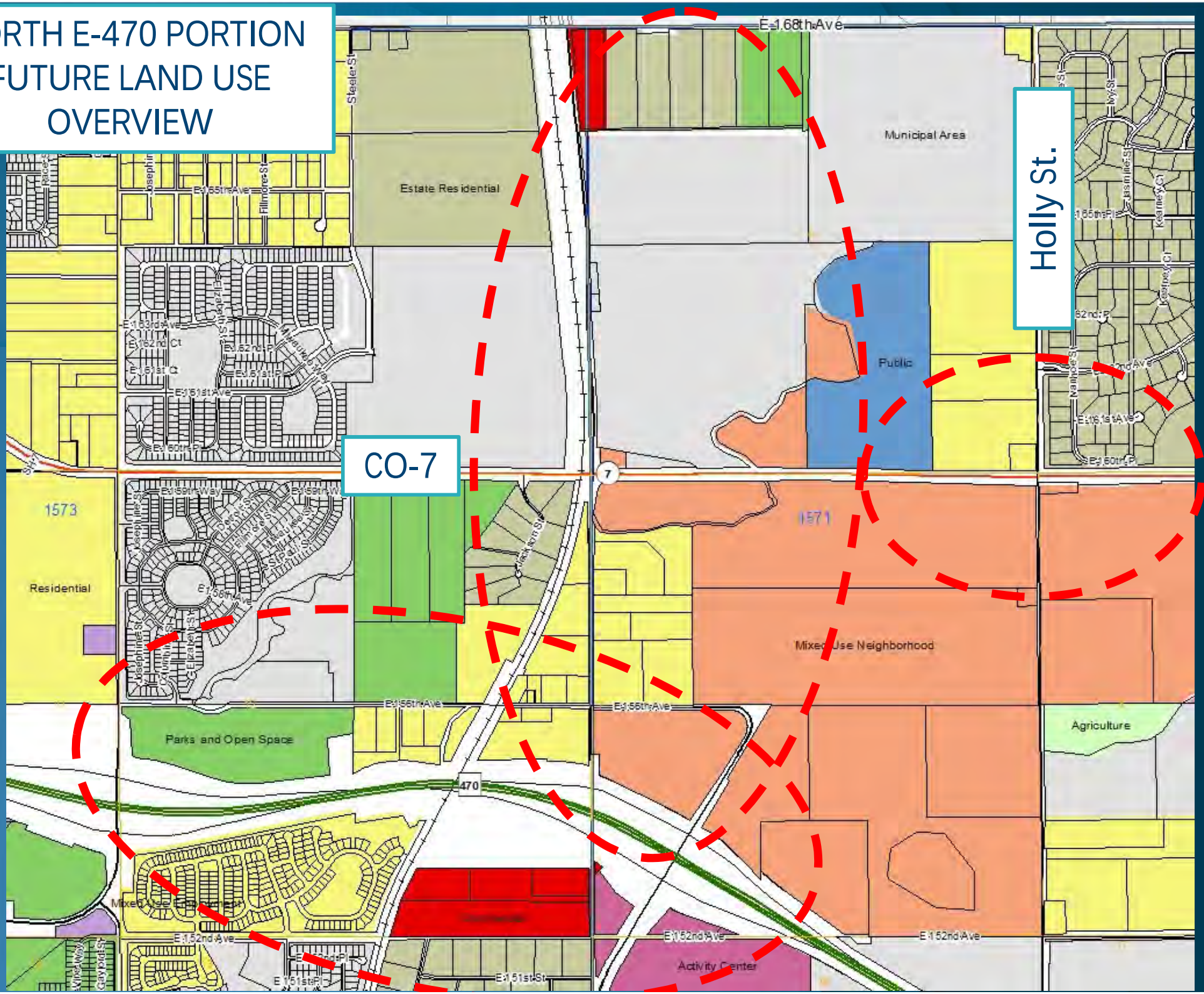

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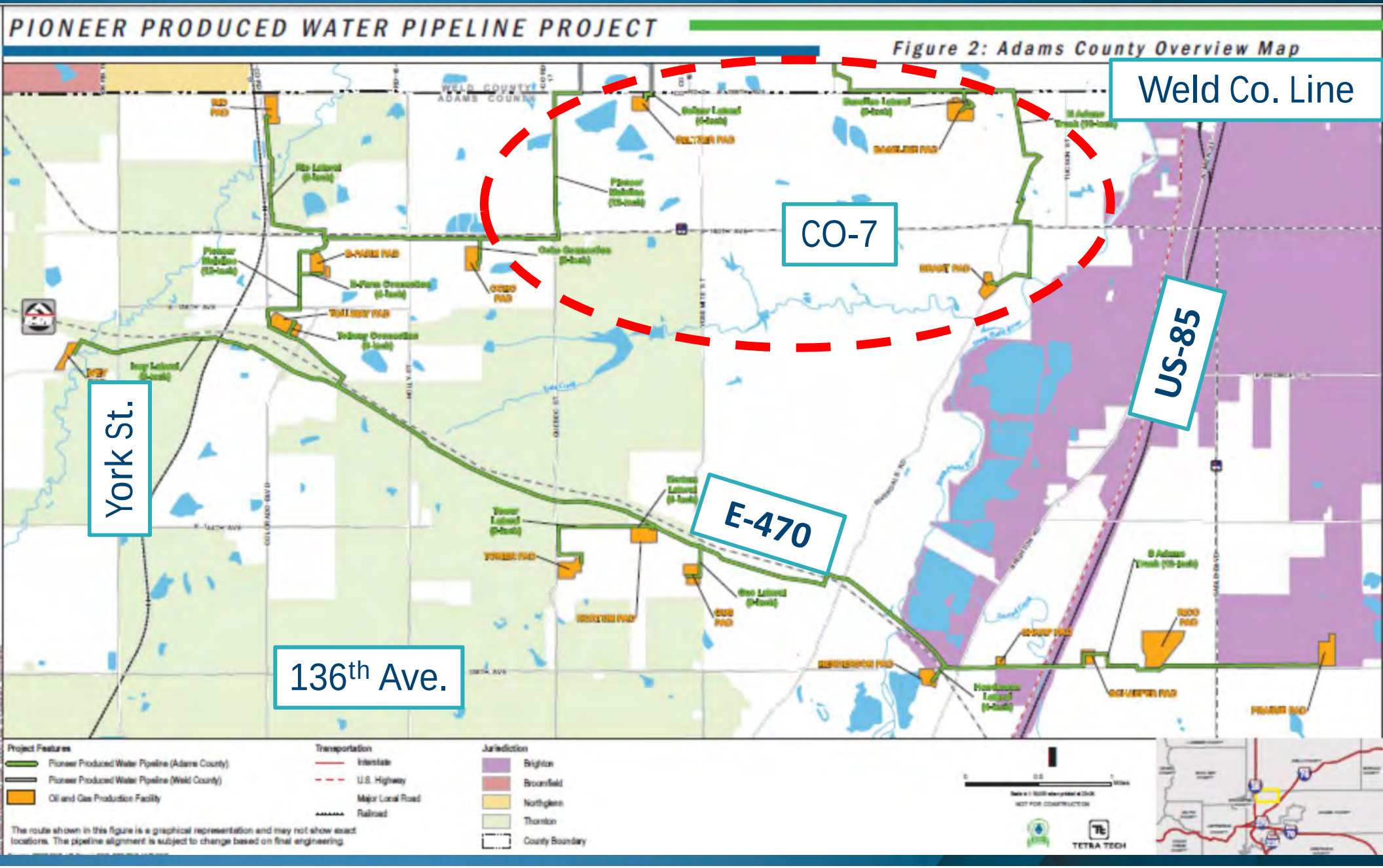

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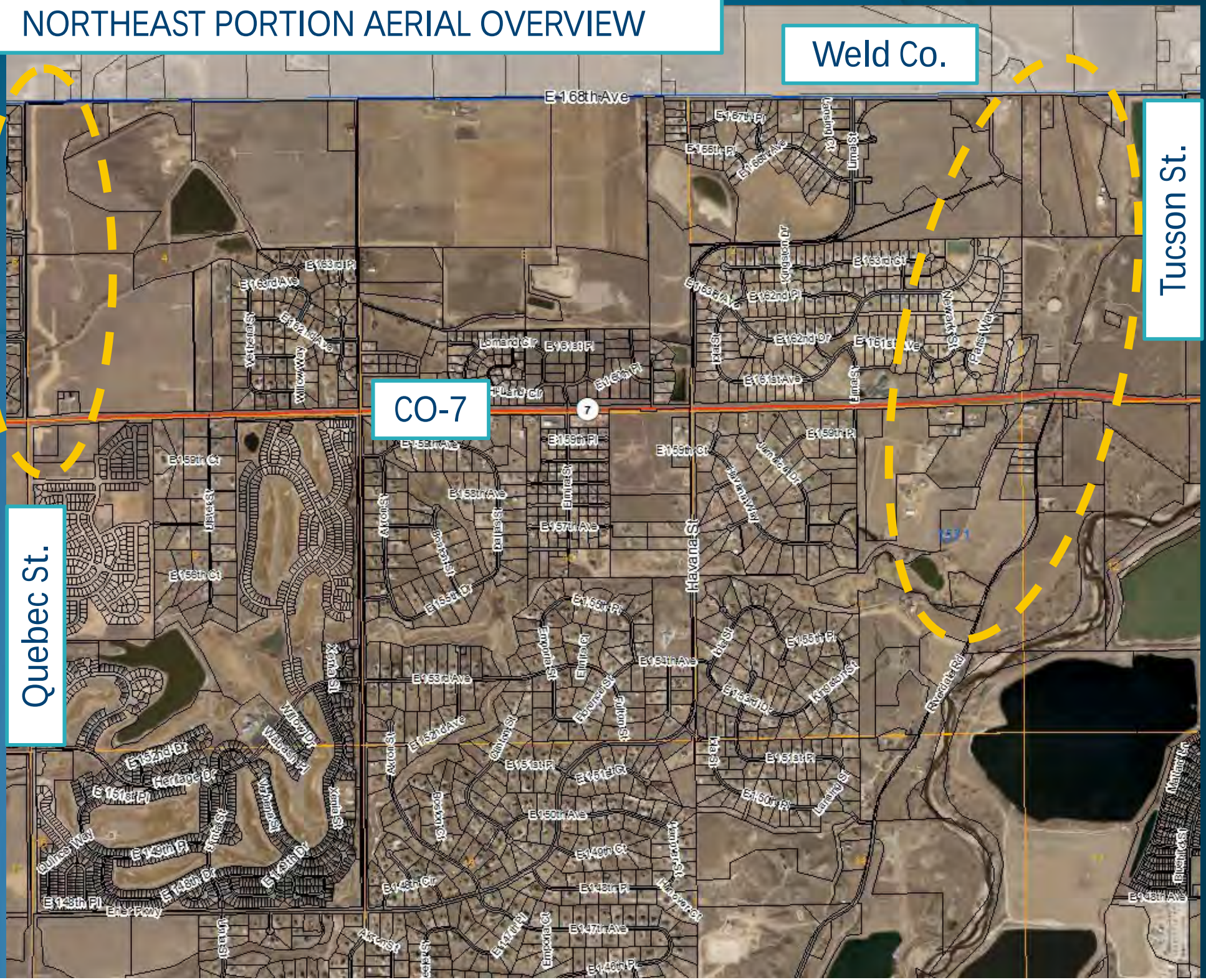

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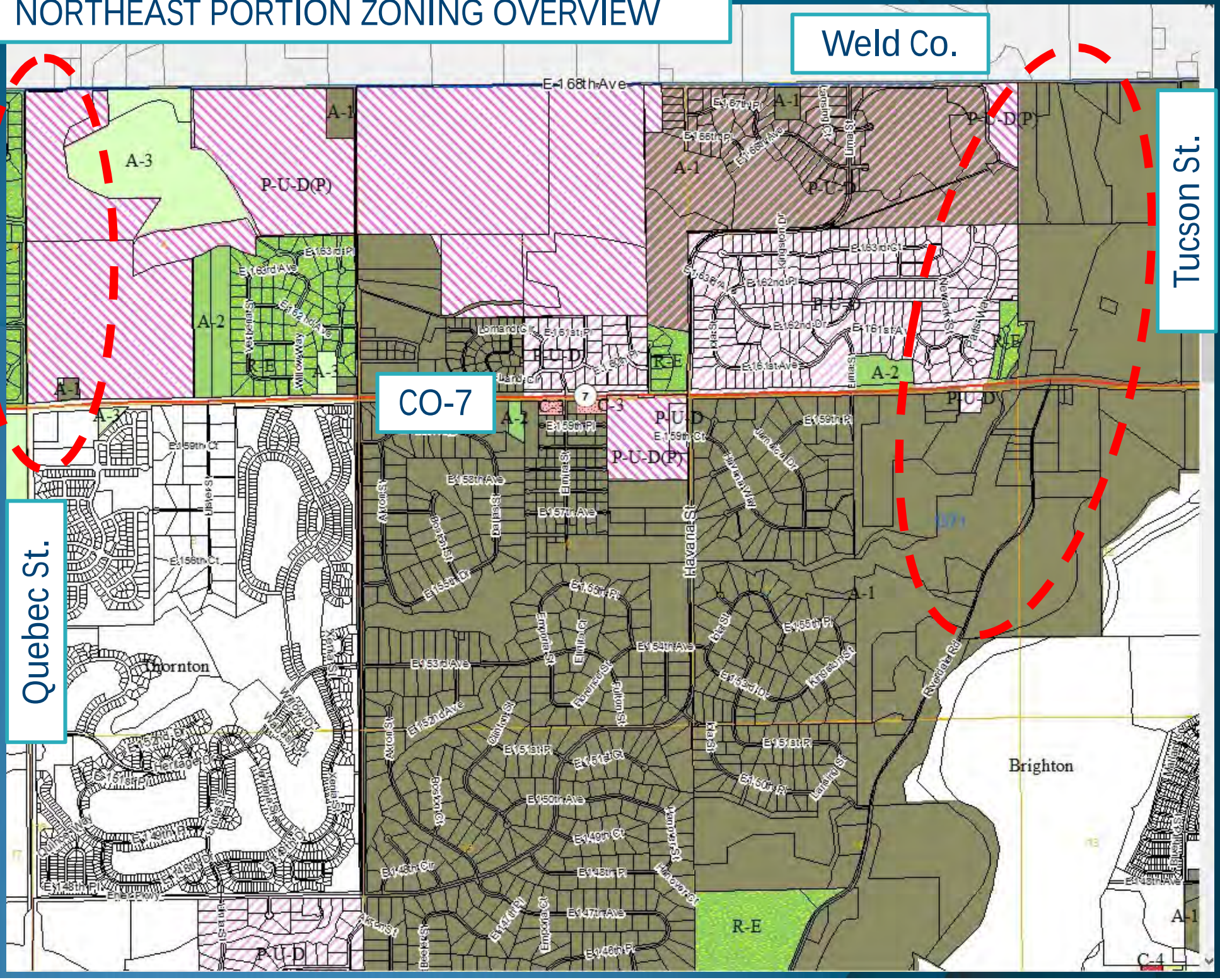

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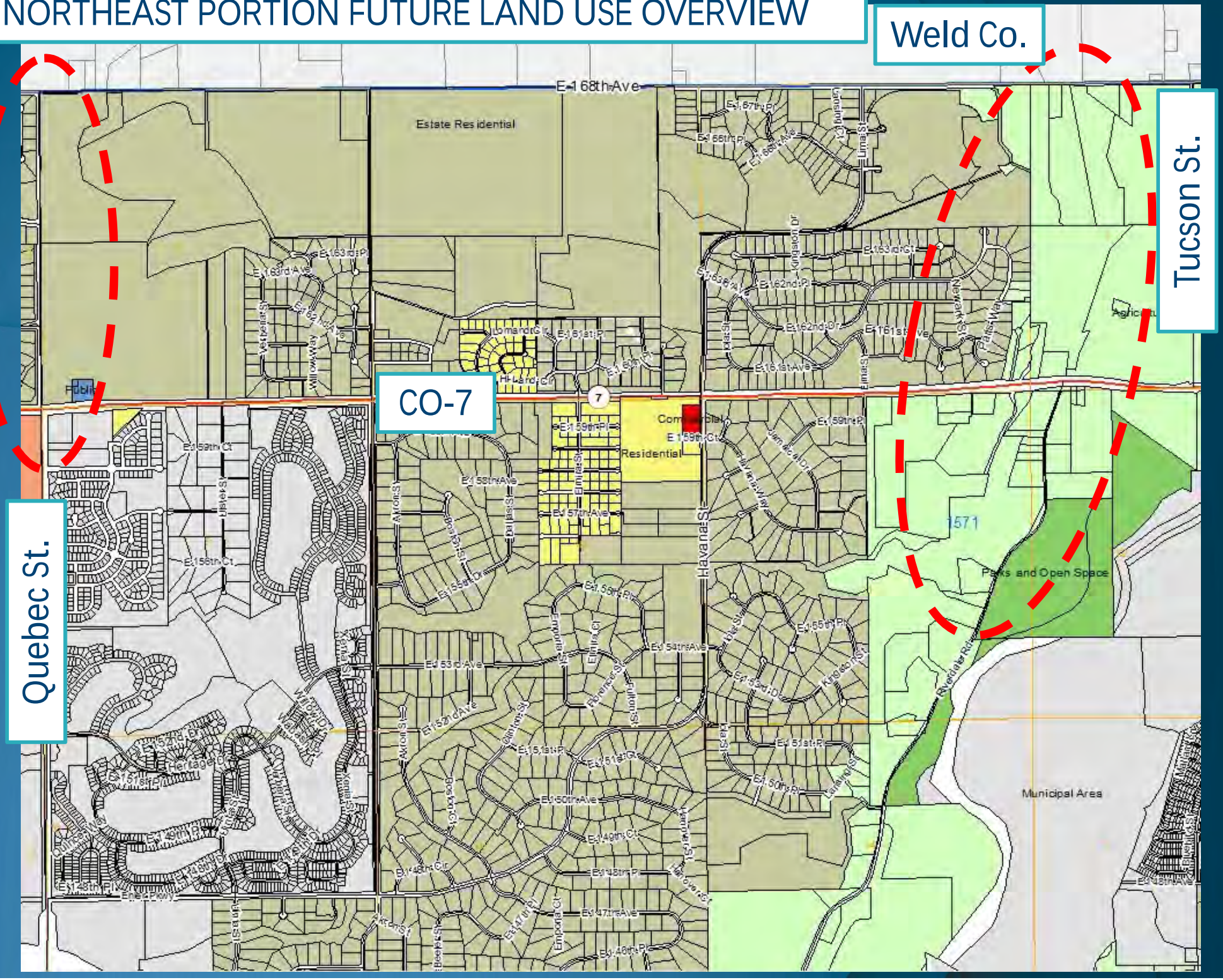


Development Agreement

- Compliance with federal safety standards & engineering codes

- Covers multiple requirements:
  - pre-construction
  - compliance with referrals
  - submittal of construction plans
  - submittal of traffic control plans
  - standards of construction for the pipeline
  - operational standards
  - ongoing maintenance of the pipeline

Criteria for Conditional Use

Section 2-02-09-06

1. Permitted in zone district
2. Consistent with purpose of regulations
3. Comply with performance standards
4. Harmonious & compatible
5. Addressed all off-site impacts
6. Site suitable for use
7. Site plan adequate for use
8. Adequate services

Additional Criteria

- 25 more criteria included from AASI:
  - Documentation on property rights
  - Technically & financially feasible
  - Natural hazards
  - Comprehensive Plan
  - Financial impacts to government / residents
  - Environmental / cultural

Referral Comments

Referral agencies

- City of Thornton
- CDPHE
- CPW
- E-470 Authority
- Metro Wastewater
- Xcel Energy

Public comments: Property owners and residents within 1,000 feet of the proposed pipeline:

Notifications Sent	Comments Received
728	1

Summary

The request is consistent with:

- Surrounding areas
- Comprehensive Plan
- Development Standards & Regulations
- AASI findings
- Benefits Region with Reduction of Traffic

Planning Commission Update

- Hearing Date: August 13, 2020
- Questions regarding safety of produced water and precautions for environmentally sensitive areas
- No public comments were provided
- Planning Commission recommended approval (6-0)

PC/Staff Recommendation

Approval of Conditional Use Permit (RCU2020-00004) and associated Development Agreement based on:

- 33 Findings-of-Fact,
- 1 condition, and
- 1 note

Recommended Condition of Approval:

1. The applicant shall comply with all the terms and conditions of the executed Development Agreement between Pioneer Water Pipeline, LLC and Adams County.

Recommended Note to Applicant:

1. The applicant shall execute the Development Agreement associated with the conditional use permit prior to the scheduled September 1, 2020 Board of County Commissioners hearing. The executed Development Agreement shall be submitted to Adams County staff no later than August 28, 2020.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

CASE NAME: ROCKY MOUNTAIN RAIL PARK
CASE NO.: PRC2019-00012

TABLE OF CONTENTS

COMMUNITY AND ECONOMIC DEVELOPMENT
DEPARTMENT STAFF REPORT

Board of County Commissioners September 1, 2020

CASE No.: **PRC2019-00012** CASE NAME: **Rocky Mountain Rail Park**	
Owner's Name:	Rail Land Company, LLC
Applicant's Name:	Rocky Mountain Industrials, LLC.
Applicant's Address:	4601 DTC Blvd. Ste 130, Denver, CO 80237
Location of Request:	Western side of Petterson Road, East of the Colorado Air and Space Port, Approximately 4,000 feet north of Interstate 70, and south of East 48th Avenue
Parcel Numbers:	0181700000289, 0181700000290, 0181700000108
Nature of Request:	1. Final Development Plan to establish the Rocky Mountain Rail Park Planned Unit Development on 620 acres; 2. Final Plat to create 11 Lots; 3. Master Development Agreement 4. Waiver from the Subdivision Design Standards
Current Zone District:	Planned Unit Development
Future Land Use:	Industrial
Total Site Area:	Approximately 620 acres
Hearing Date(s):	**BoCC: September 1, 2020 / 9:30 am**
Report Date:	August 11, 2020
Case Manager:	Nick Eagleson
PC/Staff Recommendations:	APPROVAL with 14 Findings-of-Fact, 5 Conditions, and 1 Note

SUMMARY OF APPLICATIONS

Background:
The applicant, Rail Land Company, LLC, is proposing an industrial business park on the eastern edge of the Colorado Air and Space Port. The site is located on approximately 620 acres. The eastern side of the proposed development borders Petterson Road, the western side borders the Colorado Air and Space Port, 48th Avenue is along the northern side, and the southern boundary is approximately 4,000 feet north of Interstate 70. The intended uses for the property will range from Commercial to Light and Heavy Industrial.

In order to pursue the industrial business park, Rail Land Company, LLC originally submitted four applications: 1) Comprehensive Plan Amendment to change the future land use designation on the property from Mixed-Use Employment to Industrial; 2) Zoning map amendment to change the zoning designation of the property to Planned Unit Development; 3) Preliminary Plat to create 11 lots and 11 associated tracts; 4) Preliminary Development Plan (PDP) for an industrial business park. On June 18, 2019, the Board of County Commissioners approved all four of the associated requests.

As part of the next step in the development process, Rail Land Company, LLC is requesting: 1) A final development plan (FDP) to establish the Rocky Mountain Rail Park Planned Unit Development: 2) A major subdivision final plat that encompasses three existing parcels (approximately 620 acres). The proposed final plat would create 11 lots and 11 tracts; 3) A Master Development Agreement; and 4) A waiver from the Subdivision Design Standards.

Site Characteristics:

The site is currently vacant and is bisected by U.S. Highway 36 (Colfax Avenue) and an existing railroad line. Approximately 470 acres of the proposed development is located north of Highway 36 and the rail line, while 150 acres lies to the south. The proposed development will have access to the rail line and will extend the line into the proposed development. The overall site borders three public roadways: Colfax Avenue, Petterson Road, and East 48th Avenue. The closest access to I-70 is a mile and a half to the southwest, off of Manilla Road.

Development Standards and Regulations

Final Development Plan:

A Final Development Plan (FDP) is a site-specific development plan that describes and establishes the type of intensity of uses for a specific parcel of land. Per Section 2-02-11-01 of the Adams County Development Standards and Regulations, the objective of a PUD is to establish an area of land to be developed under unified control or a unified plan of development for a number of land uses that does not correspond in lot size, bulk, or type of use, density, open space, or other restriction to the existing land use regulations. Per Section 2-02-10-04 of the Adams County Development Standards and Regulations, a Final Plat and Subdivision Improvements Agreement (SIA)are required to be submitted with a Final Development Plan. Due to the scale and complexity of this project, staff and the applicant have developed a Master Development Agreement, which meets the requirements for a SIA, while allowing for flexibility in timing of the development and associated required improvements.

A majority of the proposed lots would be accessed from an internal private street centrally located within the development. The private street will intersect East 48th Avenue on the northern side of the development and Petterson Road on the southern end. Proposed setbacks for the lots will be 40 feet from front property lines (along the private street). Side and rear setbacks are proposed to be 20 feet. The industrial lots located on the eastern edge of the development will be oriented so that Petterson Road will form their rear lot line. The proposed setbacks closely match or exceed required setbacks for the Industrial-2 and Industrial-3 zone districts, with the exception of setbacks from Petterson Road and East 48th Avenue. Setbacks for those property lines are proposed to be 20 feet, rather than the I-2 or I-3 zone district standard of 25 ft.

Below is a summary of some of the characteristics laid out within the Rocky Mountain Rail Park FDP:

Site Design and Uses

The intended uses for the Rocky Mountain Rail Park development will be a mixture of commercial and industrial. An example of some of the permitted uses within the PUD, include:

- Manufacturing
- Development and testing services
- Heavy construction contractors
- Transportation equipment

A number of heavy industrial uses with potential off-site impacts will be conditionally permitted and require review and approval by the Board of County Commissioners. These uses include:

- Hazardous Waste Treatment Facility
- Lubrication and Grease Manufacturing
- Paint and Enamel Manufacturing

This added oversight will allow for public input on proposed heavy industrial uses, as well as discretion by the Board of County Commissioners to determine how the uses might fit in with the growing Air and Space Port.

All proposed uses are subject to regulations by the Colorado Department of Public Health and Environment (CDPHE), as well as the Federal Aviation Administration (FAA). Proposed uses and structures are also subject to the Rocky Mountain Rail Park Design Standards.

Parking

Minimum parking requirements will be in accordance with Section 4-12 of the Adams County Development Standards and Regulations.

Outdoor Storage

No outdoor storage areas shall be located within 20 feet of any public road. Additionally, on an individual lot basis, outdoor storage is limited to a maximum of 80% of the overall lot area.

Colorado Air and Space Port Restrictions

All proposed development within the Rocky Mountain Rail Park shall adhere to Sections 3-34 (Airport Influence Zone) and 3-35 (Airport Noise Overlay) of the Adams County Development Standards and Regulations.

Open Space and Active Recreation

Per Section 3-30-03-05-06 of the County's Development Standards and Regulations, a minimum of 30% open space is required in all PUDs. The approved PDP provided 162.5 acres of open space, however, the applicant is now providing 175 acres of open space. A minimum of 10% of each lot is also required to be designated as open space. Section 3-30-03-05-03 of the County's Development Standards and Regulations also requires that 25% of the open space area be designated for active recreation purposes. The approved PDP provided 43.1 acres, however, the

applicant is now providing 47.2 acres of active recreation in the form of interior detached pathways adjacent to Rail Park Drive, which will create pedestrian connectivity from the north side of the park to the south side of the park. It is anticipated that the Metro District will construct and maintain covered picnic areas to serve as a gathering place for employees within the property. Perimeter pathways around detention areas will provide further walking, jogging, and running opportunities. One modification from the PDP approval and the FDP is the walking trail around the perimeter of the site. Due to concerns for public safety in areas of significant train activity and a desire to minimize rail crossings, the applicant had to eliminate the walking trail along the majority of the perimeter of the site. Open space provided will be maintained by the Rocky Mountain Rail Park Metro District.

Final Plat

Per Section 2-02-19-04 of the County's Development Standards and Regulations, the applicant is requesting approval of a final plat for the proposed development. The 620-acre site would consist of 11 lots and 11 tracts, ranging in size from 12.5 acres to approximately 131 acres. The majority of lots will be approximately 20 acres in size.

The proposed final plat conforms to the criteria for approval outlined in Section 2-02-19-04-05 of the County's Development Standards and Regulations, which include conformance to the approved preliminary plat and the subdivision design standards.

Master Development Agreement

Per Section 5-02-04 of the Adams County Development Standards and Regulations, a Subdivision Improvement Agreement (SIA) is required for the proposed development. In this case, a Master Development Agreement has been prepared for the initial phase, and subsequent SIAs will be provided for future phases of the development. The agreement is required to address the manner and timing of the completion of all subdivision improvements and responsibility for payment of the costs of improvements associated with the development. The SIA outlines the Developer's obligation for required construction and collateral for all public improvements. If any triggered improvements are to be dedicated to another jurisdiction, then the County shall not issue the Lot Development Permit until after the Developer has submitted such application materials to the regulating jurisdiction. The County shall also not issue a Certificate of Occupancy for the development until the regulatory jurisdiction has accepted the triggered improvements. Staff has reviewed the Master Development Agreement and confirmed the proposed agreements are in compliance with the County's Development Standards and Regulations.

Parkland Dedication Requirements

Per Section 5-05-02 of the Adams County Development Standards and Regulations, the Developer shall pay cash-in-lieu for 30.97 acres of the required Regional Parks dedication (representing five percent of the land area of the Subdivision), which totals $1,539,798. Section 5-05-05-03(3) of the Adams County Development Standards and Regulations allows the payment of cash-in-lieu for regional parks to be split into four payments. The first payment is due prior to recording the final plat, the second payment is due prior to the issuance of a Building Permit which would constitute greater than 25 percent of the development, the third payment is due prior to the issuance of a Building Permit which would constitute greater than 50 percent of

the development, and the fourth payment is due prior to the issuance of a Building Permit which would constitute greater than 75 percent of the development. This type of phasing plan must be approved by the Board of County Commissioners and has been incorporated into the Master Development Agreement.

Waiver from the Subdivision Design Standards

Per Section 5-03-03-09, all lots created by a subdivision shall have access to a County-maintained right-of-way. Section 5-03-03-10 states that if the Board of County Commissioners finds the most logical development of land requires lots to be created which front and are accessed by a private road, the Board of County Commissioners may make findings supporting the use of private roads in the form of a Waiver from the Subdivision Design Standards. The applicant has requested a waiver as part of this application due to hardships and practical difficulties that would result from construction and ongoing maintenance of a public right-of-way to County standards. The adjacent roadways are within the City of Aurora's jurisdiction, so if the applicant were to dedicate the internal road to Adams County, it would result in a stranded piece of road owned by Adams County within the development. It would not be cost effective for the County to provide maintenance for this road to support a small number of lots. The private road would instead be owned and maintained by the Rocky Mountain Rail Park Metro District (RMRPMD). The rail park will also have special requirements as it relates to rail crossings, which would be better managed by the RMRPMD.

Future Land Use Designation/Comprehensive Plan:

As previously mentioned, the future land use designation on the property was recently changed from Mixed-Use Employment to Industrial. The applicant intends to develop the property with uses that may be compatible with the mixed-use employment designation; however, the proposal includes the option for moderate and heavy industrial uses.

Surrounding Zoning Designations and Existing Use Activity:

Northwest AV Colorado Air & Space Port	**North** AV/A-3 Colorado Air & Space Port	**Northeast** A-3 Vacant
West AV Colorado Air & Space Port	**Subject Property** PUD Vacant	**East** City of Aurora Vacant
Southwest A-3 Vacant	**South** A-3 Vacant	**Southeast** A-3 Single-Family Residential

Compatibility with the Surrounding Area:

A majority of the properties to the east, north, and south of the proposed development are undeveloped vacant land. The Colorado Air and Space Port is directly to the west of the site. Several single-family residential uses can be found along the southeastern corner of the site. The

proposed development plan has located the moderate to heavy industrial uses to the north of Colfax Avenue.

The addition of industrial development, which will be served by a metropolitan district, will help to support the overall development of the Colorado Air and Space Port. The proposed development can serve as headquarters for employment-producing businesses that are needed to help the facility grow and serve as a catalyst for the area overall.

Staff Recommendation:
Based upon the application, the criteria for approval, and a recent site visit, staff recommends approval of this request with 14 findings-of-fact, 5 conditions, and 1 note:

RECOMMENDED FINDINGS-OF-FACT

Major Subdivision (Final Plat):

1. The final plat is consistent and conforms to the approved preliminary plat.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that a public sewage disposal system has been established and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions, have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Final Development Plan:

8. The FDP is in general conformity with the Adams County Comprehensive Plan and any applicable area plan.
9. The FDP conforms to the P.U.D. standards.
10. The FDP is consistent with any approved PDP for the property.
11. The FDP construction plans meet the requirements of these standards and regulations and have been approved by the Director of Community and Economic Development, all infrastructure and utility providers, Tri-County Health Department, and all other referral agencies.

Waiver from Subdivision Design Standards:

12. Extraordinary hardships or practical difficulties result from strict compliance with these standards and regulations.
13. The purpose of these standards and regulations are served to a greater extent by the alternative proposal.
14. The waiver does not have the effect of nullifying the purpose of these standards and regulations.

Recommended Conditions of Approval:

1. The applicant shall work with Adams County Facilities and Fleet Management Department on a "through the fence" agreement for future access from the Colorado Air and Space Port to a developable lot on along the western edge of the Rocky Mountain Rail Park site. Any future agreement would go to the Board of County Commissioners for approval.
2. The applicant shall work with Adams County Facilities and Fleet Management on a potential agreement for the rail spur, located on Adams County Property, just outside the southwest portion of the site. If an agreement cannot be made, RMRP will need to come up with an alternative solution for the spur, which does not include going through Adams County property.
3. For any future development along the western edge of the Rocky Mountain Rail Park site, screening shall be provided to mitigate the impact between the site and the Colorado Air and Space Port. The applicant shall also provide an acceptable landscape plan for each lot being developed, prior to any issuance of a building permit.
4. Any development proposed to be greater than 90 feet in height shall work with the Colorado Air and Space Port, as well as the FAA, to ensure any height requirements are met.
5. All Subdivision Improvement Agreements required by the Master Development Agreement shall include the installation of all Open Space and Active Recreation areas directly adjacent to the subject lot(s).

Recommended Note to the Applicant:

1. The applicant shall adhere to all fire, animal, health, zoning, and building codes.

CITIZEN COMMENTS

Notifications Sent	Comments Received
35	2

All property owners and occupants within 2,640 feet of the subject property were notified of the request. As of writing this report, staff has received two comments on the final development plan and final plat applications. Concerns included mosquito abatement and drainage issues from the detention ponds on the parcel south of Colfax Avenue. Berming was also brought up by the neighboring property owner. These concerns were addressed by the applicant to the satisfaction of the adjacent property owner. The other comment relates to increased traffic and infrastructure

improvements to surrounding roadways and intersections. The applicant will be working with Adams County and the City of Aurora to satisfy these requirements, which will be based on traffic studies.

COUNTY AGENCY COMMENTS

Adams County staff reviewed the subject request and determined the proposal complies with the subdivision design standards and the overall purpose and intent outlined in the Development Standards and Regulations. All lot configurations proposed conforms to lot dimensions in the PUD zone district. Evidence of the ability to provide adequate water and sewage facilitates have also been provided.

REFERRAL AGENCY COMMENTS

Responding with Concerns:

Tri-County Health Department (TCHD) - Tri-County Health Department indicated that the applicant should work with The Colorado Department of Public Health and Environment (CDPHE) to provide appropriate water and wastewater systems, including proper locations.

CDPHE – Sufficient information will need to be provided to determine the proposed water supply for the development will result in the system meeting the definition of a public water supply. The system will meet the definition of a public water supply and the applicant has met with CDPHE on multiple occasions with this understanding.

City of Aurora – The City of Aurora requests that coordination occur between Aurora, Adams County, Rocky Mountain Rail Park, Urban Drainage and Flood Control District and Transport, to discuss infrastructure needs relating to traffic, drainage, water and sewer and any other infrastructure. The applicant has been in discussions with each party to discuss coordinating these items and a provision has been added to the Master Development Agreement that necessitates the applicant to meet all City of Aurora engineering requirements prior to issuance of any building permits. The applicant has incorporated the results of the City of Aurora's Northeast Aurora Transportation Study (NEATS) into their recent plat submittal, which was a condition of approval from the approved preliminary plat.

Colorado Department of Transportation (CDOT) – CDOT requests that access permits are required for any access taken from State Highway 36. The applicant is aware and will be applying for access permits when necessary.

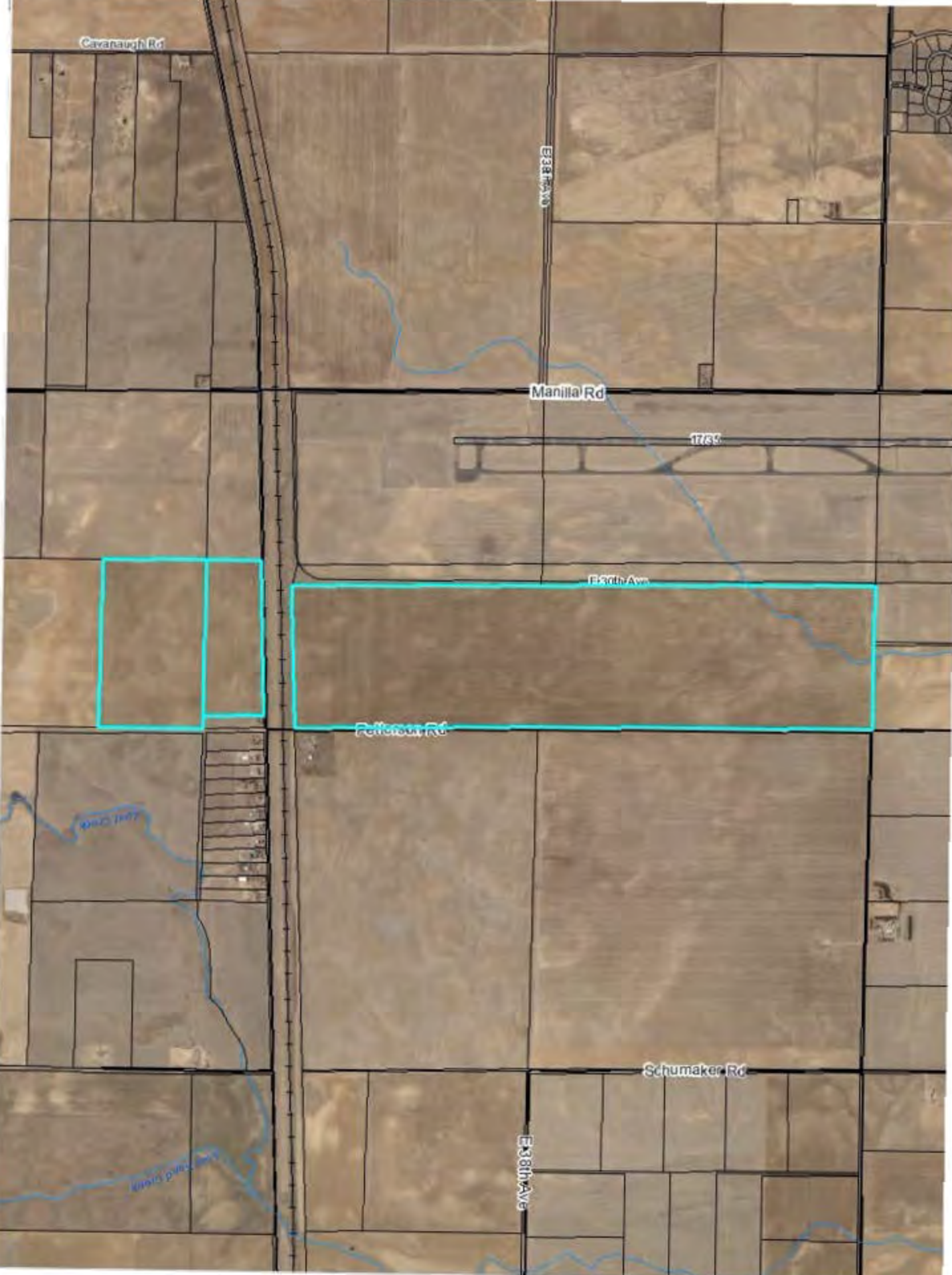
Mile High Flood District (MHFD) – MHFD will require the applicant to make all necessary improvements to Crooked Creek.

Responding without Concerns:

Arapahoe County
Colorado Geological Survey
Colorado Division of Water Resources
Xcel Energy

Federal Aviation Administration

Notified but not Responding / Considered a Favorable Response:
Adams County Parks Department
Adams County Sheriff
Bennett Fire Protection
Bennett Parks and Recreation
Bennett School District
Century Link
Colorado Division of Minerals and Geology
Colorado Division of Parks and Wildlife
Comcast
Denver International Airport
Metro Waste Water
Union Pacific Railroad
US Environmental Protection Agency
US Post Office
Qwest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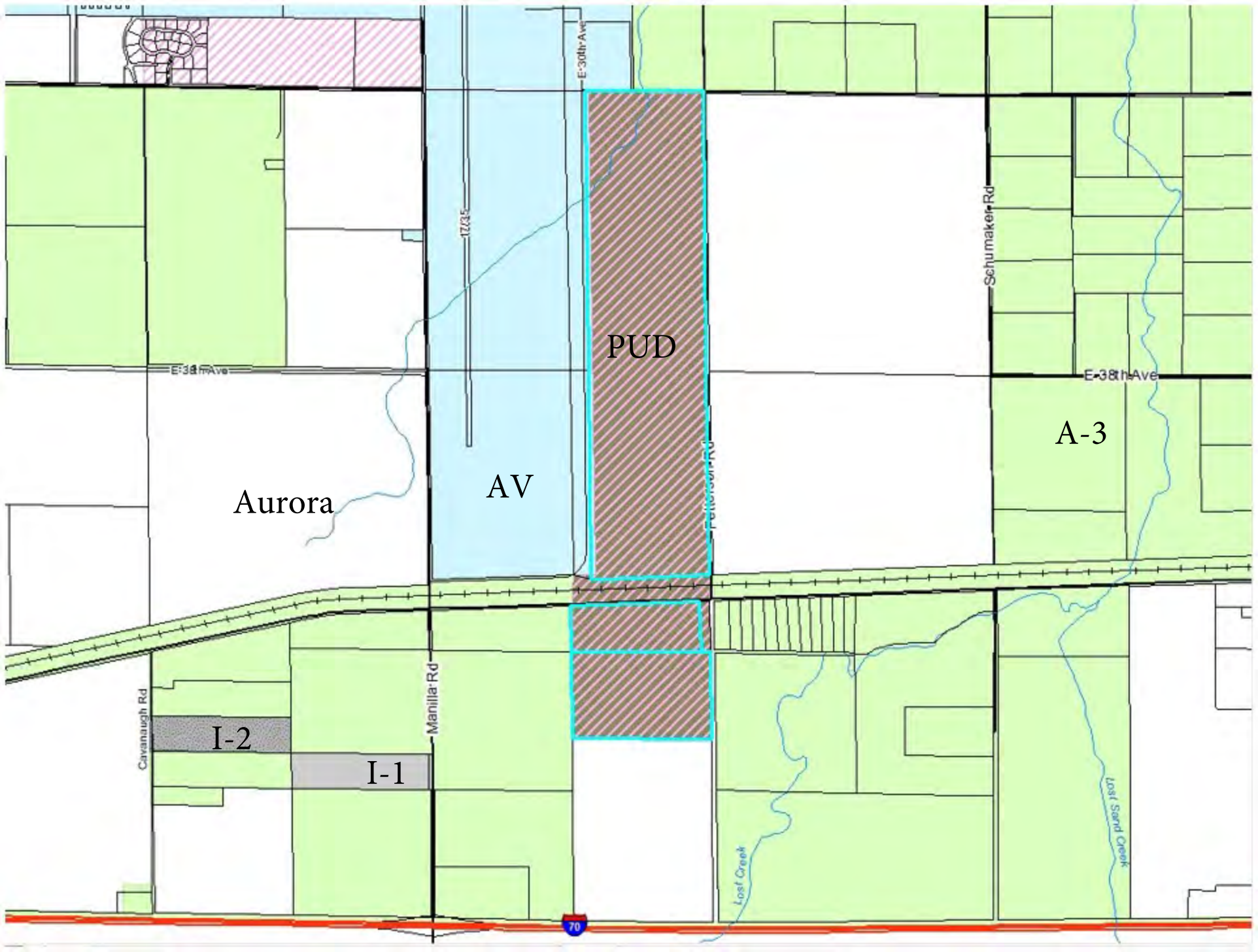
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I-2
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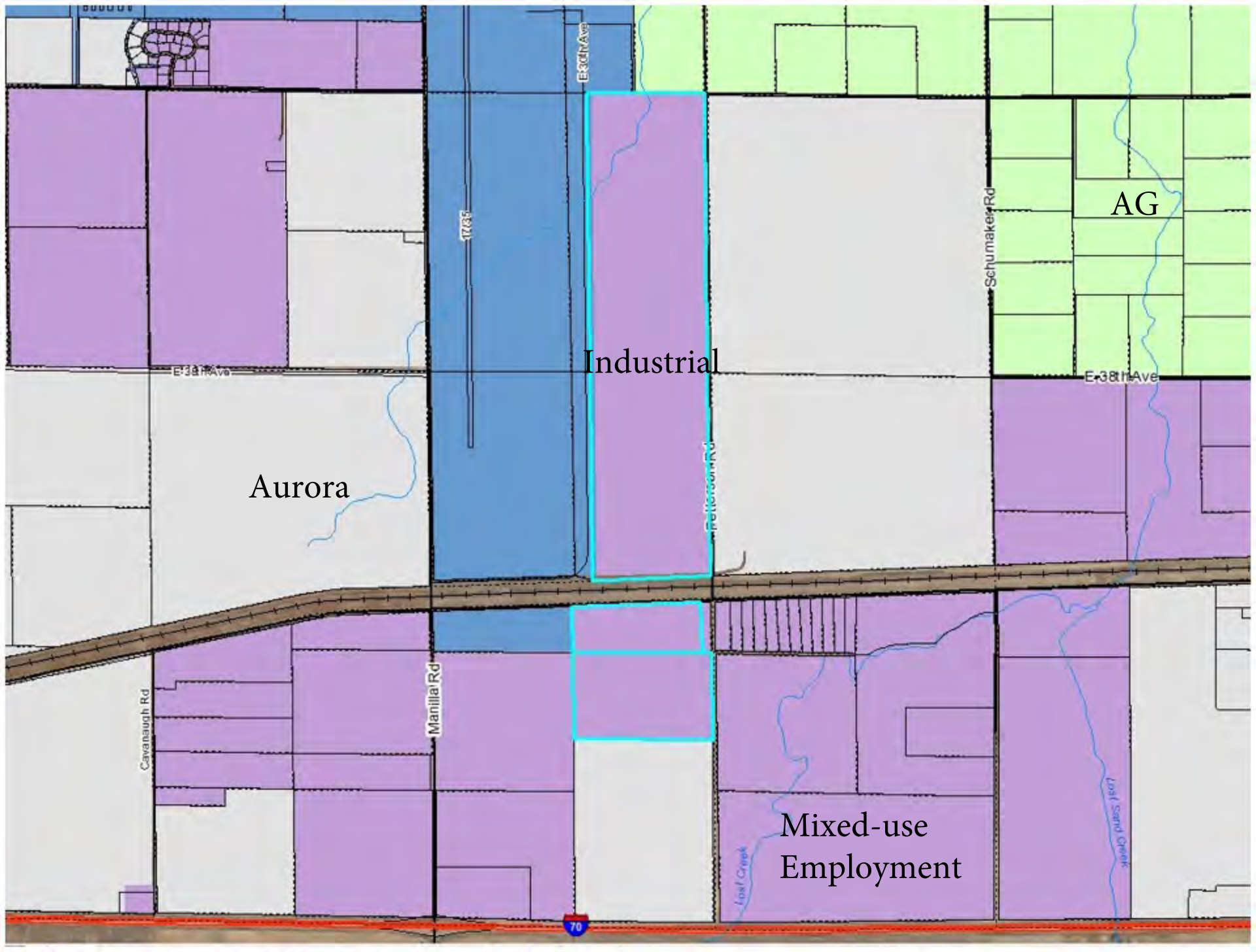
Schumaker-Rd
Manilla-Rd
Cavanaugh Rd
Lost Creek
Lost Sand Creek
70


AG
Industrial
Aurora
Mixed-use
Employment
E-38th Ave
Schumaker Rd
Manilla Rd
Cavanaugh Rd
Lost Creek
Lost Sand Creek
70

Rail Land Company, LLC
4601 DTC Blvd, Ste 130
Denver, Colorado

Project Info

Project Name:	Rocky Mountain Rail Park
Project Location:	North of E Colfax Ave between Manilla Road and Petterson Road
Submittal Item:	Written Explanation of the Project

October 14, 2019

Adams County Planning Department
4430 S. Adams County Pkwy
Brighton, CO 80601

Dear Mr. Barnes,

Rail Land Company, LLC ("RLC") is pleased to present this written explanation of the Rocky Mountain Rail Park project. The proposed project is an industrial and commercial rail park located in Adams County that includes 11 lots, over 4 miles of rail, and over 3 miles of road on 619.75 acres. The project includes a newly formed metro district that will provide water, sanitary, storm, and landscape services and maintenance, and will be the entity that constructs many of the improvements.

Location

The site is currently located on 2 parcels of land near the Colorado Air and Space Port ("CASP"). Parcel 1 is a 2-mile long parcel that is bounded to the west by CASP, to the south by a Union Pacific main line, to the east by Peterson Rd, and to the north by 48th Avenue. Parcel 2 is bounded to the north by E Colfax Ave, to the east by Petterson Road (and a single residential property in a notch at the NE corner), to the south by un-platted farmland, and to the west by un-platted farmland.

Intent

The Rail Park is intended to provide developable industrial property to future landowners looking to expand their presence in central Adams County. The project is further intended to provide rail access to individual lots so that landowners will have the capability of importing and exporting materials by rail (via rail access to individual properties), by truck (via access to major roadways), or by air (via CASP). The proposed lot sizes are large enough to accommodate most potential landowners including significant storage capability. This will provide excellent capability to support tenants that support infrastructure projects, distribution projects, and countywide development projects.

Background

Private developers, cities, and counties have utilized industrial land for mixed-use, urban renewal projects, and residential infill projects resulting in industrial users like RLC to look further outside the city limits for industrial property. North Denver and Commerce City, the main industrial sections of the greater metropolitan area, were intentionally planned to be far from the more populated residential and commercial centers. As the region's population has grown, most of those industrial properties are being redeveloped for more valuable residential and commercial projects. RLC identified the requirement for new industrially zoned real estate in order to accommodate the heavy industry necessary to supply the growing consumer and residential growth. A decreased availability of industrial property and increased need for affordable construction products created the foundation of RMRP.

The greater Denver marketplace demands efficient and affordable freight distribution to support and enable the high rate of market expansion. Infrastructure materials are the foundation of the industrial economy. If not kept in balance, higher costs for building supplies, roads, homes, and transportation assets can lead to higher taxes and inflation. As part of the solution, RLC chose Adams County as the new center of industry.

Development Considerations

One of the primary considerations with developing industrial property is the need to be a good neighbor to the surrounding community. As a result, RLC spent considerable effort to determine ways to minimize impact to surrounding property. This includes extensive visual screening using berms and walls, significantly lowering the rail grade on the site to minimize noise and visual impacts, and creating development standards that minimize impacts from light.

The project's unique location next to Colorado Air and Space Port affords it the ability to minimize project impacts to other adjacent landowners for two miles along the western and part of northern property line. It's location against the Union Pacific Rail main line to the south further reduces adjacent impacts. Because the site is already within a noise overlay zone with other noise generating uses, the addition of the rail park will not have as significant an impact as it might if it were located away from other potential noise sources.

Regardless of the reduced number of potential adjacent receptors, RMR incorporated design features that minimize impact to the surrounding community. Recognizing that Parcel 2 shares a small section of property line with an existing residential structure, RMR has spoken with these tenants and is making considerable effort to minimize noise impacts and visually screen the property. We have located detention ponds in locations that provide further buffers, and the development does not propose any rail operations south of Colfax Avenue.

Sites with rail operations have extensive design constraints associated with grades, radiuses, crossings, and many legal considerations. RLC has had weekly meetings with the Union Pacific throughout the entire project design phase, and has had separate meetings with other jurisdictional agencies including the Public Utilities Commission, City of Aurora, Urban Drainage Flood Control District, Bennet-Watkins Fire, Rocky Mountain Rail Park Metro

District, CDOT, CDPHE, and others. Beyond the typical design considerations required by Adams County, RLC has worked to incorporate design requirements (and requests) from all jurisdictional agencies.

Utilities

Natural gas and electricity for the project will be provided by Colorado Natural Gas and Xcel Energy, respectively. Water and wastewater service will be provided by the newly created Metro District. This special district will also provide regional stormwater management, road maintenance, landscape maintenance, and utility infrastructure maintenance. Fire protection is provided by the Bennett-Watkins Fire Department.

The utilities are described in greater detail in the utility sections of this submittal, however, generally, the site will be self-sufficient by supplying its own water treatment plant, sanitary treatment plant and the associated collection and distribution infrastructure. Adams County will not be required to construct or maintain any infrastructure.

Construction Sequence and Schedule

The project has been under design for almost two years and we anticipate site grading operations to begin in Winter (2019-2020) to Spring 2020. This is contingent upon Adams County approving the proposed Final Development Plan.

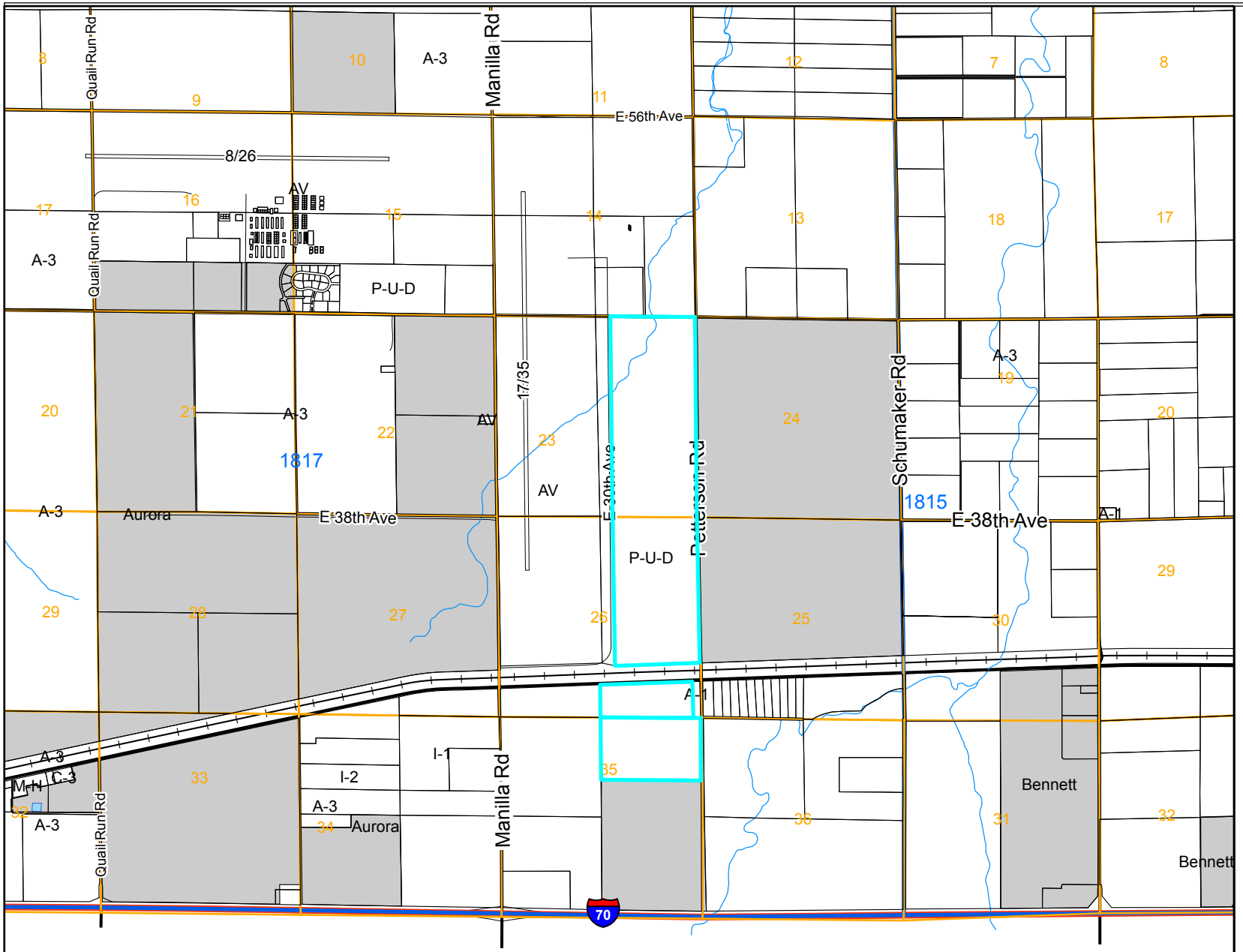
We anticipate that development will occur from the south to north with critical infrastructure being constructed first, and in some cases simultaneously with lot specific development activities. We recognize that this is somewhat atypical for small scale development, but this is common for large construction projects that have longer development timeframes. For example, mass grading activities will take approximately 4 to 6 months and treatment system installation is likely to take 6 months. It will not be possible to wait until infrastructure is completed before building permits on lots are approved. Development on the lots themselves may take upwards of a year during which time infrastructure is being constructed. The included Subdivision Improvement Agreement (SIA) provides more detail regarding how we intend to proceed. We anticipate working closely with Bennett-Watkins Fire and Adams County to make sure that all life-safety requirements are met during development activities.

Rail Land Company appreciates all of the work performed by Adams County as well as the various agencies that have had an impact on this project. We look forward to our continuing relationships as this project moves forward and respectfully request your approval of our Final Development Plan.

Respectfully,

Gregory M. Dangler, President

ROCKY MOUNTAIN



Legend

- Railroad
- Major Water
- Zoning Line
- Sections

Case Name: Rocky Mountain Rail Park

Case Number: PRC2019-00012

N

For display purposes only.

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

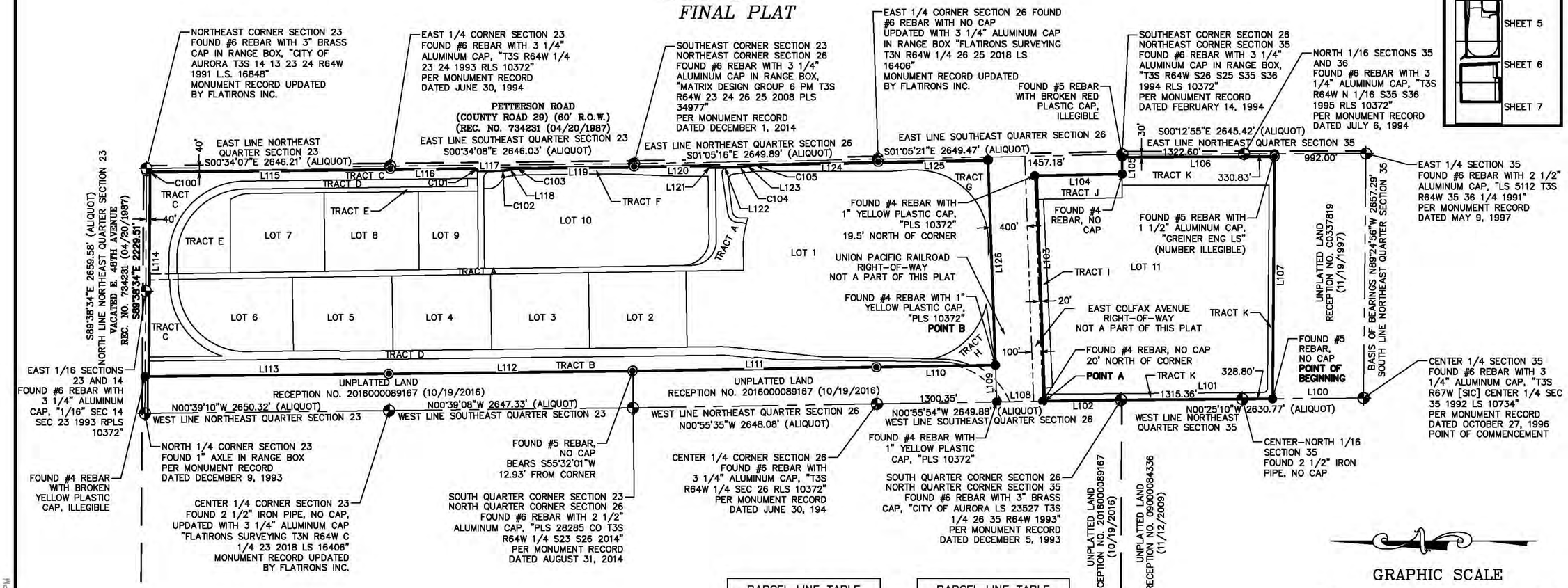
ROCKY MOUNTAIN RAIL PARK FILING NO. 1

PRC2019-00012

LOCATED IN THE EAST HALF OF SECTION 23, THE EAST HALF OF SECTION 26 AND THE NORTHEAST QUARTER OF SECTION 35, TOWNSHIP 3 SOUTH, RANGE 64 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO

SHEET 2 OF 7

FINAL PLAT



OWNERSHIP AND MAINTENANCE TABLE					
LOTS	AREA	OWNER	DEDICATIONS	MAINTENANCE	USE
LOT 1	131.55	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 2	19.98	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 3	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 4	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 5	20.00	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 6	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 7	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 8	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 9	12.49	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 10	54.86	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 11	121.59	RAIL LAND COMPANY, LLC		OWNER	PUD
SUB TOTAL LOT AREA (AC)	460.42				
TRACTS					
TRACT A	15.34	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	ACCESS, DRN, LA, OS, U
TRACT B	27.86	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT C	24.13	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT D	25.38	RAIL LAND COMPANY, LLC		OWNER	PUD
TRACT E	12.82	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT F	6.90	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT G	9.78	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT H	3.62	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT I	3.66	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT J	5.44	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT K	18.46	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
SUB TOTAL TRACT AREA (AC)	153.39				
TOTAL	613.81				

**RMRPMD = ROCKY MOUNTAIN RAIL PARK METRO DISTRICT
RLC, LLC = RAIL LAND COMPANY, LLC

PARCEL LINE TABLE		
LINE #	LENGTH	DIRECTION
L100	986.62	N00°25'10"W
L101	1644.15	N00°25'10"W
L102	829.46	N00°55'54"W
L103	2449.56	N87°55'30"E
L104	929.60	S01°04'32"E
L105	184.56	S89°44'09"E
L106	1653.32	S00°12'55"E
L107	2630.74	N89°31'58"W
L108	520.07	N00°55'54"W
L109	400.10	N87°55'30"E
L110	1292.35	N00°55'54"W
L111	2646.15	N00°55'37"W
L112	2647.33	N00°39'08"W
L113	2603.27	N00°39'07"W

PARCEL LINE TABLE		
LINE #	LENGTH	DIRECTION
L114	2196.82	S89°38'33"E
L115	2584.22	S00°34'06"E
L116	923.12	S00°34'07"E
L117	268.06	S00°34'07"E
L118	147.82	S08°23'52"E
L119	1258.36	S00°34'07"E
L120	821.89	S01°05'16"E
L121	20.00	S89°12'16"W
L122	324.35	S01°05'16"E
L123	148.79	S08°12'46"E
L124	1331.48	S01°05'16"E
L125	1191.75	S01°05'20"E
L126	2222.37	S87°55'30"W

CURVE TABLE					
CURVE #	LENGTH	RADIUS	DELTA	CHORD DIRECTION	CHORD LENGTH
C100	35.76	23.00	89°04'27"	S45°06'20"E	32.26
C101	35.13	23.00	87°30'29"	S43°11'07"W	31.81
C102	15.99	117.00	7°49'45"	S04°29'00"E	15.97
C103	11.34	83.00	7°49'45"	S04°29'00"E	11.33
C104	14.55	117.00	7°07'30"	S04°39'01"E	14.54
C105	10.32	83.00	7°07'30"	S04°39'01"E	10.31

GRAPHIC SCALE

800 0 400 800 1600

(IN FEET)

1 inch = 800 ft.

Legend

- FOUND ALIQUOT MONUMENT AS DESCRIBED
- FOUND MONUMENT AS DESCRIBED
- SET 18" #5 REBAR WITH 1 1/2" ALUMINUM CAP "FLATIRONS SURV 16406"
- BOUNDARY LINE
- ADJACENT PROPERTY LINE
- LOT AND/OR TRACT LINE
- SECTION LINE
- RIGHT-OF-WAY LINE
- EXISTING EASEMENT LINE

Overall Boundary

Flatirons, Inc.
Surveying, Engineering & Geomatics
www.FlatironsInc.com
3825 IRIS AVE, STE 395
BOULDER, CO 80301
PH: (303) 443-7001
FAX: (303) 443-9830

(SEAL)

JOB NUMBER:	18-71,096
DATE:	08/17/2020
DRAWN BY:	M. VOYLES
CHECKED BY:	BO/JZG/JK/ETB

BY:MVOYLES FILE:71096_ROCKY MOUNTAIN RAIL PARK FILING NO. 1.DWG DATE:8/18/2020 1:27 PM

After Recording Return To:
Jill Jennings Golich, Director
Adams County Community and Economic Development
1st Floor, Suite W2000A
4430 South Adams County Parkway
Brighton, Colorado 80601

MASTER DEVELOPMENT AGREEMENT FOR ROCKY MOUNTAIN RAIL PARK

THIS MASTER DEVELOPMENT AGREEMENT FOR ROCKY MOUNTAIN RAIL PARK ("MASTER AGREEMENT") is made and entered into by and between the BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF ADAMS, State of Colorado, hereinafter "COUNTY," and RAIL LAND COMPANY, LLC d/b/a ROCKY MOUNTAIN RAIL PARK, a Colorado limited liability company, hereinafter "DEVELOPER" (each a "PARTY," or collectively, the "PARTIES").

RECITALS

WHEREAS, Developer is the owner of approximately 619.45 acres real property in the County of Adams, State of Colorado, as described in **Exhibit A** attached hereto, and by this reference made a part hereof ("PROPERTY"), commonly known as the Rocky Mountain Rail Park ("SUBDIVISION");

WHEREAS, the Subdivision will facilitate the development of a rail park adjacent to the Colorado Air and Space Port ("CASP"), and is designed to allow rail delivery to individual end users and further the economic development of the County;

WHEREAS, the subdivision statutes of the State of Colorado, C.R.S. § 30-28-137, and the subdivision resolution of the County authorize the execution of an agreement between the County and Developer whereby Developer agrees to construct any required public improvements for the Subdivision, and to provide security for completion of the public improvements that are within the County's jurisdiction;

WHEREAS, due to the size and complexity of the Subdivision, as well as economic cycles and market conditions that will impact the term of absorption, this Agreement provides for the completion of certain public improvements ("FUTURE IMPROVEMENTS") within the Subdivision and outside of the Subdivision when warranted by development activities within the Subdivision;

WHEREAS this Master Agreement will serve to ensure that the Future Improvements are completed concurrently with, or before, the completion of development within the Subdivision that creates the impacts that create the demand for such improvements, and that security and warranties will be provided to the County according to the County's adopted requirements, which are included in the form Development Agreement ("DA") attached as **Exhibit B**;

WHEREAS, this Master Agreement is consistent with the purpose of Planned Unit Development ("PUD") zoning for the Subdivision, which is to permit detailed development planning as development occurs to allow flexibility in adapting to market demands while protecting and promoting the public health, safety, and welfare of existing and future residents of Adams County, and relieving the County from the cost of completing the Future Improvements; and

WHEREAS, the Parties agree that the impacts of the Subdivision as approved will be fully addressed by this Master Agreement and the subsequent Development Agreements between the County, and the Parties acknowledge that surety may be required for Future Improvements as detailed in those subsequent Development Agreements.

NOW, THEREFORE, in consideration of the foregoing and upon approval and recordation of the final plat of the Subdivision, the parties hereto promise, covenant, and agree as follows:

1. **Incorporation of Recitals**. The Recitals above are fully incorporated herein and made a part hereof.

2. **Future Improvements**.

2.1 *Generally*. The Parties agree that the Future Improvements are not yet warranted and are likely to be influenced by specific development plans proposed by subsequent purchasers of individual lots within the Subdivision ("LOTS"). Future Improvements will be required if and when certain thresholds ("THRESHOLDS") identified in Master Traffic Impact Study, as defined in Section 2.2, below, are met. If and when a Threshold is met, Developer shall design and construct the Future Improvements as set forth herein.

2.2 *Master Traffic Impact Study*. Developer submitted for review, and the County approved, a Master Traffic Impact Study ("MASTER STUDY"). The Master Study analyzes the entire Subdivision at full build-out of all Lots. The Master Study identifies the Future Improvements that are necessary to mitigate for impacts of the fully developed Subdivision and identifies traffic count Thresholds for when specific Future Improvements will be required (when thresholds are met or exceeded, such Future Improvements will be referred to herein as "TRIGGERED IMPROVEMENTS"). The Master Study was prepared at Developer's sole cost and expense. A summary of the Future Improvements contemplated by the Master Study is attached as **Exhibit C**. To the extent of any conflict between the Master Study and Exhibit C, the Master Study shall control.

2.3 *Development of Lots.* THE DEVELOPER ACKNOWLEDGES THAT THE TIME REQUIRED FOR PROCESSING APPLICATIONS FOR LOT DEVELOPMENT PERMITS, AS DEFINED BELOW, MAY BE EXTENDED BY A REASONABLE PERIOD DUE TO THE ADDITIONAL PROCESSING REQUIREMENTS OF THIS SECTION, AND THAT SAID EXTENTION OF TIME IS NECESSARY TO ACCOMMODATE THE DEVELOPER'S REQUEST (AND THE COUNTY'S AGREEMENT) TO ALLOW FOR THE TIMING OF CONSTRUCTION OF FUTURE IMPROVEMENTS AS PROVIDED IN

THIS AGREEMENT. Along with any application for construction, building, or change-in-use permits for a Lot that may result in an increase in trip generation (each, a "LOT DEVELOPMENT PERMIT"), the Developer shall prepare a Traffic Impact Study ("TIS"), at the Developer's sole cost and expense, and submit the TIS to the County for review and approval (a TIS is not required for subsequent applications for Lot Development Permits that generate traffic that was previously accounted for in a prior TIS). The TIS shall be used to determine whether Triggered Improvements are required. The TIS must include a Trip Generation analysis for the subject Lot, address its cumulative impacts with all previously developed Lots, and provide analysis regarding whether the proposed development or use requires the construction of Triggered Improvements. Actual traffic counts shall be used (in lieu of Trip Generation calculations) for previously developed Lots, if Certificates of Occupancy have been issued for those Lots and a use is established such that their traffic impacts may be measured. If Triggered Improvements are not required, the Developer may apply for a Lot Development Permit in accordance with the County's Development Standards and Regulations. If Triggered Improvements are required, the TIS must identify them with particularity, and *in addition to all other applicable requirements for issuance of a Lot Development Permit*:

2.3.1 If the Triggered Improvements are to be dedicated to or otherwise under control of the County, then Developer shall submit an executed DA and collateral to the County as provided in Section 5, below.

2.3.2 If the Triggered Improvements are to be dedicated to another jurisdiction ("REGULATING JURISDICTION"), then County shall not issue the Lot Development Permit until after the Developer has submitted such application materials to the Regulating Jurisdiction as its adopted regulations require for construction of such Triggered Improvements; and the County shall not issue a Certificate of Occupancy for the development or use authorized by the Lot Development Permit until the Regulatory Jurisdiction has accepted the Triggered Improvements (preliminary acceptance, subject to Developer warranty, shall be considered acceptance for the purposes of this provision).

2.4 *Drainage Improvements*.

2.4.1 SUB-AREAS FOR DRAINAGE PURPOSES. The Subdivision is separated into two distinct development areas, divided by Colfax Avenue. For the purposes of describing the drainage improvement, the "North Area" is defined as the area north of Colfax Avenue, and the "South Area" is defined as the area south of Colfax Avenue.

2.4.2 Prior to or simultaneously with the development of the first Lot in the North Area, Developer shall complete all required drainage improvements in the North Area and the swales to the east and west of the development (*i.e.*, Crooked Run and Crooked Run East). Alternatively, the County may administratively approve a series of temporary drainage improvements if it finds that they adequately address the demands of proposed

development, and allow for sequential construction of the permanent drainage system as approved for the Subdivision.

2.4.3 Prior to or simultaneously with the development of the first Lot in the South Area, Developer shall complete all required drainage improvements in the South Area.

3. **Engineering Services**. Developer shall furnish or cause to have furnished, without cost to the County, all engineering services in connection with the design and construction of Triggered Improvements that are required pursuant to this Master Agreement when construction of such Triggered Improvements is required. Developer shall obtain, or cause to have obtained the approval from the County or other applicable Regulating Jurisdiction for all construction plans and engineering reports in connection with the design and construction of said Triggered Improvements. It is the Developer's responsibility to satisfy the requirements of Section 2.3.2 by notifying the County of its application to a Regulating Jurisdiction and the subsequent acceptance by the Regulating Jurisdiction of completed Triggered Improvements. The Developer shall promptly provide such interim documentation (e.g., construction permits, inspection reports, etc.) regarding construction of Triggered Improvements as the County may request from time to time, provided such documentation is then available to the Developer.

4. **Drawings and Estimates**. At or before the time that a TIS associated with a Lot Development Permit identifies that one or more Triggered Improvements are required, Developer shall furnish, or cause to have furnished, drawings and cost estimates for the Triggered Improvements that are then warranted, to (and for approval by) the County or other Regulating Jurisdiction, as applicable. Nothing in this Section 4 shall be interpreted to require Developer to furnish more or less information to the Regulating Jurisdiction than it would otherwise require.

5. **Development Agreement.**

5.1 *Generally*. DAs that are required by this Agreement shall be submitted in the form attached hereto as **Exhibit B**, in order to provide for construction and (as applicable) warranty of the Triggered Improvements then required, according to the drawings and materials approved by the County.

5.2 *Cost of Construction Exhibit.* Developer shall attach to the DA the design and a corresponding Engineer's Opinion of Probable Cost ("EOPC") (together, the "COST OF CONSTRUCTION EXHIBIT") for the applicable Triggered Improvement, to detail the costs used in determining the Surety requirement as defined in the DA. Construction costs shall be estimated by a registered Colorado Engineer, who must sign and stamp the EOPC exhibit.

5.3 *Public Improvement Construction Schedule Exhibit.* The Cost of Construction Exhibit shall include a completion deadline for all of the improvements included therein. Developer shall not commence construction prior to approval of the DA for that Lot and all prerequisites to

construction outlined in the DA, and receipt of the appropriate Grading Permit, Access Permit, and/or Right-of-Way ("ROW") Permit from the County.

5.4 *Provisions for Surety*. Surety to the County shall be in an amount equal to estimated cost to construct the Future Improvement plus twenty percent (20%) to cover administration and five percent (5%) per year of the term of the DA to cover inflation. Draws under any such Surety shall follow the procedures set out in the Surety and the requirements of the Adams County Development Standards and Regulations ("ACDS&R"), which shall be consistent with the DA. Release of Surety shall be in accordance with the requirements of the Adams County Development Standards and Regulations.

5.5 *Other Regulating Jurisdictions*. Developer shall follow such protocols as adopted by other Regulating Jurisdictions with regarding to permitting and surety for Future Improvements within their jurisdictions. The County will not require the Developer to provide Surety to the County for Future Improvements to be constructed in or for other Regulating Jurisdictions.

6. **Public Land Dedication.** Pursuant to Section 5-05-05-02-01, ACDS&R, Developer shall pay cash-in-lieu for 30.9725 acres of regional parks (representing five percent of the land area of the Subdivision), totaling one million five hundred thirty-nine thousand seven hundred ninety-eight and no / 100 dollars **($1,539,798.00)**. Pursuant to Section 5-05-05-03(3), ACDS&R, the payment of cash-in-lieu for regional parks shall be split into four payments. The first payment is due prior to recording the final plat, the second payment is due prior to the issuance of a Building Permit which would constitute greater than 25 percent of the development, the third payment is due prior to the issuance of a Building Permit which would constitute greater than 50 percent of the development, and the fourth payment is due prior to the issuance of a Building Permit which would constitute greater than 75 percent of the development. The cash-in-lieu set out in this Section 6 shall represent the maximum cash-in-lieu required from the Subdivision for regional parks; however, if the County amends the ACDS&R at any time prior to the fourth payment, to provide for: (a) a lower cash-in-lieu payment for property that is comparable to the Subdivision due to either industrial or PUD zoning that allows comparable uses; or (b) an appeal or individual calculation methodology to reduce amounts due based on the individual characteristics of a development, then Developer may apply for a reduction of its total payment according to such updated or amended County regulations and apply that reduction to the balance due to the County.

7. **Default by Developer.** A default by Developer under this Master Agreement shall exist after notice and an opportunity to cure of not less than 10 days, as hereinafter provided, if: (a) Developer fails to cure any noncompliance specified in any written notice of noncompliance from the County within a reasonable time after receipt of the notice of noncompliance; (b) Developer otherwise breaches or fails to comply with any obligation of Developer under this Agreement; or (c) Developer becomes insolvent, files a voluntary petition in bankruptcy, is adjudicated a bankrupt pursuant to an involuntary petition in bankruptcy, or a receiver is appointed for Developer. An administrative determination by the County that the Developer is in default shall be appealable to the Board of County Commissioners.

8. **Protection of Innocent Purchasers.** This Agreement is entered into pursuant to the requirements of the ACDS&R and C.R.S. § 30-28-137(1)(b). It is therefore subject to the provisions of C.R.S. § 30-28-137.

9. **Successors and Assigns.** This Agreement shall be binding upon the heirs, executors, personal representatives, successors, and assigns of Developer, and shall be deemed a covenant running with the real property as described in **Exhibit A** attached hereto.

10. **Assignability**.

    10.1 *Assignment to District*. County acknowledges that the Rocky Mountain Rail Park Metro District ("DISTRICT") has been formed for the purpose of constructing and maintaining certain improvements within the Property. The County hereby consents to the performance by the District of any of the obligations of the Developer hereunder. Upon the assignment by the Developer of all or a portion of the Developer's obligations hereunder to the District and the assumption of such obligation by the District, the Developer shall be released from such assigned obligation, and the County will accept performance of such assigned obligation from the District.

    10.2 *Assignment to Others*. Developer may assign its rights and obligations under this Agreement to a party who is the successor or assignee of Developer in its capacity as developer of the Subdivision without the consent of the County; provided, however, that: (a) Developer notifies the County of the assignment and of the name and address of the successor developer; and (b) the successor Developer assumes the obligations of Developer under this Agreement. Unless otherwise agreed by County, Developer shall remain liable for performance of the obligations of Developer under this Agreement. The County shall release a surety furnished by Developer if the County accepts new security from any successor Developer of the Subdivision.

11. **Miscellaneous.**

    11.1 *Notices*. Any notice or communication required under this Agreement must be in writing, and may be given either personally or by registered or certified mail, return receipt requested. If given by registered or certified mail, the same will be deemed to have been given and received on the first to occur of (a) actual receipt by any of the addressees designated below as the party to whom notices are to be sent, or (b) five days after a registered or certified letter containing such notice, properly addressed, with postage prepaid, is deposited in the United States mail. If personally delivered, a notice will be deemed to have been given when delivered to the party to whom it is addressed. Any party hereto may at any time, by giving written notice to the other party hereto as provided in this Section, designate additional persons to whom notices or communications will be given and designate any other address in substitution of the address to which such notice or communication will be given. Such notices or communications will be given to the parties at their addresses set forth below:

If to the County:

Board of County Commissioners
County of Adams
4430 South Adams County Parkway
Brighton, CO 80601
Attention: Chair

With a required copy to:
Adams County Attorney
4430 South Adams County Parkway
Brighton, CO 80601
Attention: County Attorney

If to Owner:

Rail Land Company, LLC
d/b/a Rocky Mountain Rail Park
4601 DTC Boulevard, Suite 130
Denver, CO 80237

With a required copy to:
Fairfield and Woods, P.C.
1801 California Street, Suite 2600
Denver, Colorado 80203
Attention: Rita Connerly, Esq.

11.2 *Further Assurances*. At any time, and from time to time, upon request of either Party, the other Party agrees to make, execute and deliver or cause to be made, executed and delivered to the requesting Party any and all further instruments, certificates, or documents consistent with the provisions of this Agreement as may, in the reasonable opinion of the requesting party, be necessary or desirable in order to effectuate, complete, or perfect the right of the Parties under this Agreement.

11.3 *Binding Effect*. Subject to Section 9, above, this Agreement shall run with the land and be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

11.4 *Headings for Convenience*. All headings and captions used herein are for convenience only and are of no meaning in the interpretation or effect of this Agreement.

11.5 *Severability*. If any provision of this Agreement is declared by a court of competent jurisdiction to be invalid, it shall not affect the validity of this Agreement as a whole or any part thereof other than the part declared to be invalid and there shall be substituted for the affected provision, a valid and enforceable provision as similar as possible to the affected provision.

11.6 *No Waiver of Governmental Immunity*. Nothing contained in this Agreement shall constitute a waiver of the governmental immunity under applicable state law.

11.7 *Consent to Jurisdiction and Venue*. Personal jurisdiction and venue for any civil action commenced by either party to this Agreement with respect to this Agreement or a surety shall be proper only if such action is commenced in the District Court for Adams County, Colorado.

11.8 *Third-Party Beneficiaries*. This Master Agreement is intended to provide for the construction of infrastructure to support development within unincorporated Adams County, Colorado, and while non-parties are named in this Master Agreement, it is intended only for the benefit of the Parties hereto and their respective permitted successors and assigns, and is not for the benefit of, nor may any provision hereof be enforced by, any other person, organization, entity, or political subdivision.

11.9 *Force Majeure*. Neither party shall be liable for failure to perform hereunder if such failure is the result of Force Majeure and any time limit expressed in this Agreement shall be extended for the period of any delay resulting from any Force Majeure. "Force Majeure" shall mean causes beyond the reasonable control of a party such as, but not limited to, weather conditions, acts of God, acts of terrorism, strikes, work stoppages, unavailability of or delay in receiving labor or materials, faults by contractors, subcontractors, utility companies or third parties, fire or other casualty, pandemic disease, or action of government authorities.

11.10 *Entire Agreement*. This Agreement, and any agreement or document referred to herein, constitutes the entire understanding between the parties with respect to the subject matter hereof and all other prior understandings or agreements shall be deemed merged in this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

[Signature Pages Follow]

RAIL LAND COMPANY, LLC,
a Colorado limited liability company

By: _____
Authorized Signatory

STATE OF COLORADO }
} ss.
CITY AND COUNTY OF DENVER }

The foregoing instrument was acknowledged before me this _____ day of _____, 2020, by _____ as authorized signatory for Rail Land Company, LLC, a Colorado limited liability company.

My commission expires:_____

Address: _____ _____
Notary Public

_____

APPROVED BY resolution at the meeting of _____, 2020.

ATTEST:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____
Clerk of the Board

_____
Chair

APPROVED AS TO FORM:

_____
County Attorney

EXHIBIT A

LEGAL DESCRIPTION
ROCKY MOUNTAIN RAIL PARK

EXHIBIT "A"

LOCATED IN THE SOUTHEAST QUARTER OF SECTION 26 AND THE NORTHEAST QUARTER OF SECTION 35, TOWNSHIP 3 SOUTH, RANGE 64 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO

SHEET 1 OF 2

A PARCEL OF LAND LOCATED IN THE SOUTHEAST QUARTER OF SECTION 26 AND THE NORTHEAST QUARTER OF SECTION 35, TOWNSHIP 3 SOUTH, RANGE 64 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO

CONSIDERING THE SOUTH LINE OF THE NORTHEAST QUARTER OF SECTION 35 TO BEAR NORTH 89°24'01" WEST, A DISTANCE OF 2657.29 FEET BETWEEN THE EAST QUARTER CORNER OF SECTION 35, BEING A FOUND #6 REBAR WITH 2 1/2" ALUMINUM CAP, "LS 5112 T3S R64W 35 36 1/4 1991" AND THE CENTER QUARTER OF SECTION 35, BEING A FOUND #6 REBAR WITH 3 1/4" ALUMINUM CAP, "T3S R67W [SIC] CENTER 1/4 SEC 35 1992 LS 10734" WITH ALL BEARINGS SHOWN HEREON ARE RELATIVE THERETO.

COMMENCING AT SAID CENTER QUARTER CORNER OF SECTION 35; THENCE ALONG THE WEST LINE OF THE NORTHEAST QUARTER OF SECTION 35, NORTH 00°24'15" WEST, A DISTANCE OF 986.62 FEET TO THE POINT OF BEGINNING; THENCE CONTINUING ALONG SAID WEST LINE, NORTH 00°24'15" WEST, A DISTANCE OF 1644.15 FEET TO THE SOUTH QUARTER CORNER OF SECTION 26; THENCE ALONG THE WEST LINE OF THE SOUTHEAST QUARTER OF SECTION 26, NORTH 00°54'59" WEST, A DISTANCE OF 849.46 FEET TO POINT ON THE SOUTH RIGHT-OF-WAY LINE OF EAST COLFAX AVENUE; THENCE ALONG SAID SOUTH RIGHT-OF-WAY LINE, NORTH 87°56'25" EAST, A DISTANCE OF 2449.51 FEET; THENCE SOUTH 01°03'37" EAST, A DISTANCE OF 949.60 FEET TO THE SOUTH LINE OF THE SOUTHEAST QUARTER OF SECTION 26; THENCE ALONG SAID SECTION LINE, SOUTH 89°43'06" EAST, A DISTANCE OF 184.57 FEET TO A POINT ON THE WEST RIGHT-OF-WAY LINE OF PETERSON ROAD; THENCE ALONG SAID WEST RIGHT-OF-WAY LINE, SOUTH 00°12'00" EAST, A DISTANCE OF 1653.32 FEET; THENCE DEPARTING SAID RIGHT-OF-WAY LINE, NORTH 89°31'02" WEST, A DISTANCE OF 2630.74 FEET TO A PONT ON THE WEST LINE OF THE NORTHEAST QUARTER OF SECTION 35, SAID POINT ALSO BEING THE POINT OF BEGINNING.

SAID PARCEL CONTAINING 6,545,869 SQ. FT. OR 150.27 ACRES MORE OR LESS.

I, JOHN B. GUYTON, A LAND SURVEYOR LICENSED IN THE STATE OF COLORADO, DO HEREBY STATE FOR AND ON BEHALF OF FLATIRONS, INC., THAT THIS PARCEL DESCRIPTION AND ATTACHED EXHIBIT, BEING MADE A PART THEREOF, WERE PREPARED BY ME OR UNDER MY RESPONSIBLE CHARGE AT THE REQUEST OF THE CLIENT AND IS NOT INTENDED TO REPRESENT A MONUMENTED LAND SURVEY OR SUBDIVIDE LAND IN VIOLATION OF STATE STATUTE.

16406
4/18/18
PROFESSIONAL LAND SURVEYOR

JOHN B. GUYTON
COLORADO P.L.S. #16406
CHAIRMAN/CEO, FLATIRONS, INC.

FSI JOB NO. 18-71,096

JOB NUMBER: 18-71,096 DRAWN BY: M. VOYLES DATE: APRIL 17, 2018 (PARCEL 1)
THIS IS NOT A "LAND SURVEY PLAT" OR "IMPROVEMENT SURVEY PLAT" AND THIS EXHIBIT IS NOT INTENDED FOR PURPOSES OF TRANSFER OF TITLE OR SUBDIVISIONS OF LAND. RECORD INFORMATION SHOWN HEREON IS BASED ON INFORMATION PROVIDED BY CLIENT.

Flatirons, Inc.
Surveying, Engineering & Geomatics
3825 IRIS AVE, STE 395
BOULDER, CO 80301
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www.FlatironsInc.com

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EXHIBIT "A"

LOCATED IN THE SOUTHEAST QUARTER OF SECTION 26 AND THE NORTHEAST QUARTER OF SECTION 35, TOWNSHIP 3 SOUTH, RANGE 64 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO

SHEET 2 OF 2

JOB NUMBER: 18-71,096 DRAWN BY: M. VOYLES DATE: APRIL 17, 2018 (PARCEL 1)
THIS IS NOT A "LAND SURVEY PLAT" OR "IMPROVEMENT SURVEY PLAT" AND THIS EXHIBIT IS NOT INTENDED FOR PURPOSES OF TRANSFER OF TITLE OR SUBDIVISIONS OF LAND. RECORD INFORMATION SHOWN HEREON IS BASED ON INFORMATION PROVIDED BY CLIENT.

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EXHIBIT "A"

LOCATED IN THE EAST HALF OF SECTIONS 26 AND 23, TOWNSHIP 3 SOUTH,
RANGE 64 WEST OF THE 6TH PRINCIPAL MERIDIAN,
COUNTY OF ADAMS, STATE OF COLORADO

SHEET 1 OF 2

A PARCEL OF LAND LOCATED IN THE EAST HALF OF SECTIONS 26 AND 23, TOWNSHIP 3 SOUTH, RANGE 64 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

CONSIDERING THE SOUTH LINE OF THE NORTHEAST QUARTER OF SECTION 35 AS BEARING NORTH 89°24'01" WEST, A DISTANCE OF 2657.29 FEET BETWEEN THE EAST QUARTER CORNER OF SECTION 35, BEING A FOUND #6 REBAR WITH 2 1/2" ALUMINUM CAP, "LS 5112 T3S R64W 35 36 1/4 1991" AND THE CENTER QUARTER OF SECTION 35, BEING A FOUND #6 REBAR WITH 3 1/4" ALUMINUM CAP, "T3S R67W [SIC] CENTER 1/4 SEC 35 1992 LS 10734" WITH ALL BEARINGS SHOWN HEREON ARE RELATIVE THERETO.

COMMENCING AT SAID CENTER QUARTER CORNER OF SECTION 35; THENCE ALONG THE WEST LINE OF THE NORTHEAST QUARTER OF SECTION 35, NORTH 00°24'15" WEST, A DISTANCE OF 2630.77 FEET TO THE SOUTH QUARTER CORNER OF SECTION 26; THENCE ALONG THE WEST LINE OF THE SOUTHEAST QUARTER OF SECTION 26, NORTH 00°54'59"W, A DISTANCE OF 1349.52 FEET TO POINT ON THE NORTH RIGHT-OF-WAY LINE OF THE UNION PACIFIC RAILROAD; THENCE ALONG SAID NORTH RIGHT-OF-WAY LINE, NORTH 87°56'25"E, A DISTANCE OF 400.05 FEET TO THE POINT OF BEGINNING; THENCE NORTH 00°54'59"W, A DISTANCE OF 1292.35 FEET; THENCE NORTH 00°54'42"W, A DISTANCE OF 2647.11 FEET; THENCE NORTH 00°38'13"W, A DISTANCE OF 2646.37 FEET; THENCE NORTH 00°38'12"W, A DISTANCE OF 2643.27 FEET; TO A POINT ON THE NORTH LINE OF THE NORTHEAST QUARTER OF SECTION 23; THENCE ALONG SAID NORTH LINE, THENCE SOUTH 89°37'39"E, A DISTANCE OF 2229.51 FEET TO A POINT ON THE WEST RIGHT-OF-WAY LINE OF PETERSON ROAD; THENCE ALONG SAID WEST RIGHT-OF-WAY LINE THE FOLLOWING FOUR (4) COURSES:

1) SOUTH 00°33'11"E, A DISTANCE OF 2646.70 FEET;
2) THENCE SOUTH 00°33'13"E, A DISTANCE OF 2646.16 FEET;
3) THENCE SOUTH 01°04'21"E, A DISTANCE OF 2650.03 FEET;
4) THENCE SOUTH 01°04'25"E, A DISTANCE OF 1191.58 FEET TO A POINT ON SAID NORTH RIGHT-OF-WAY LINE OF THE UNION PACIFIC RAILROAD; THENCE ALONG SAID RIGHT-OF-WAY LINE, SOUTH 87°56'25" WEST, A DISTANCE OF 2232.37 FEET TO THE POINT OF BEGINNING.

SAID PARCEL CONTAINING 20,437,415 SQ. FT. OR 469.18 ACRES MORE OR LESS.

I, JOHN B. GUYTON, A LAND SURVEYOR LICENSED IN THE STATE OF COLORADO, DO HEREBY STATE FOR AND ON BEHALF OF FLATIRONS, INC., THAT THIS PARCEL DESCRIPTION AND ATTACHED EXHIBIT, BEING MADE A PART THEREOF, WERE PREPARED BY ME OR UNDER MY RESPONSIBLE CHARGE AT THE REQUEST OF THE CLIENT AND [illegible] INTENDED TO REPRESENT A MONUMENTED LAND SURVEY OR SUBDIVIDE LAND IN VIOLATION OF STATE STATUTE.

16406
4/18/18

JOHN B. GUYTON
COLORADO P.L.S. #164[illegible]
CHAIRMAN/CEO, FLATIRO[illegible]

FSI JOB NO. 18-71,096

JOB NUMBER: 18-71,096 DRAWN BY: M. VOYLES DATE: APRIL 17, 2018 (PARCEL 2)
THIS IS NOT A "LAND SURVEY PLAT" OR "IMPROVEMENT SURVEY PLAT" AND THIS EXHIBIT IS NOT INTENDED FOR PURPOSES OF TRANSFER OF TITLE OR SUBDIVISIONS OF LAND. RECORD INFORMATION SHOWN HEREON IS BASED ON INFORMATION PROVIDED BY CLIENT.

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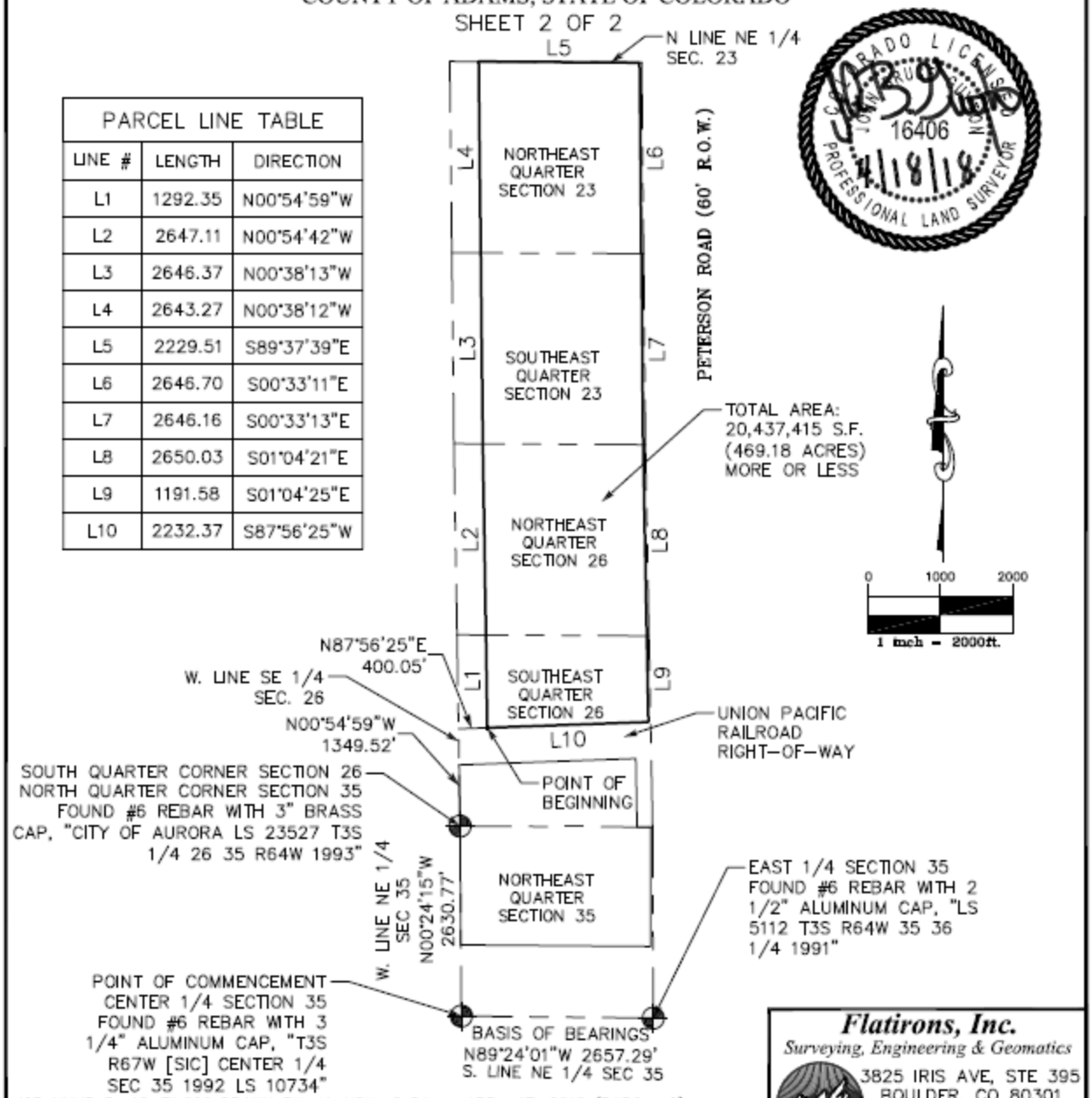
EXHIBIT "A"

LOCATED IN THE EAST HALF OF SECTIONS 26 AND 23, TOWNSHIP 3 SOUTH,
RANGE 64 WEST OF THE 6TH PRINCIPAL MERIDIAN,
COUNTY OF ADAMS, STATE OF COLORADO

SHEET 2 OF 2

PARCEL LINE TABLE		
LINE #	LENGTH	DIRECTION
L1	1292.35	N00°54'59"W
L2	2647.11	N00°54'42"W
L3	2646.37	N00°38'13"W
L4	2643.27	N00°38'12"W
L5	2229.51	S89°37'39"E
L6	2646.70	S00°33'11"E
L7	2646.16	S00°33'13"E
L8	2650.03	S01°04'21"E
L9	1191.58	S01°04'25"E
L10	2232.37	S87°56'25"W



COLORADO LICENSED
JOHN R. BULLOCK
16406
4/18/18
PROFESSIONAL LAND SURVEYOR

JOB NUMBER: 18-71,096 DRAWN BY: M. VOYLES DATE: APRIL 17, 2018 (PARCEL 2)
THIS IS NOT A "LAND SURVEY PLAT" OR "IMPROVEMENT SURVEY PLAT" AND THIS EXHIBIT IS NOT INTENDED FOR PURPOSES OF TRANSFER OF TITLE OR SUBDIVISIONS OF LAND. RECORD INFORMATION SHOWN HEREON IS BASED ON INFORMATION PROVIDED BY CLIENT.

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EXHIBIT B

FORM OF DEVELOPMENT AGREEMENT

DEVELOPMENT AGREEMENT

THIS AGREEMENT is made and entered into this ___ day of _____, 20__, between _____, a _____ corporation qualified to do business in Colorado ("Developer"), whose address is _____ and the Board of County Commissioners of the County of Adams, State of Colorado ("County"), whose address is 4430 S. Adams County Parkway, Brighton, CO 80601.

WITNESSETH:

WHEREAS, Developer is the owner of real property in the County of Adams, State of Colorado, within the Rocky Mountain Rail Park Subdivision, such real property as described in Exhibit "A" attached hereto, and by this reference made a part hereof.

WHEREAS, Real property within the Rocky Mountain Rail Park Subdivision is subject to the terms of that certain Master Development Agreement for Rocky Mountain Rail Park, dated _____, 2020 and recorded in the Public Records of Adams County on _____, 2020 at Reception No. _____ ("Master Agreement").

WHEREAS, this Development Agreement implements the requirements of the Master Agreement.

WHEREAS, it is provided by resolution of the Board of County Commissioners, County of Adams, that where designated the Developer shall have entered into a written agreement with the County to install public and/or private improvements, and to deed land for public purposes or right-of-way.

NOW, THEREFORE, in consideration of the foregoing, the parties hereto promise, covenant, and agree as follows:

1. **Engineering Services**. Developer shall furnish, at its own expense, all engineering and other services in connection with the design and construction of the improvements described and detailed on Exhibit "B" attached hereto, and by this reference made a part hereof ("Improvements").

2. **Drawings and Estimates**. The Developer shall furnish drawings and cost estimates for all improvements described and detailed on Exhibit "B" for approval by the County. Upon request, the Developer shall furnish one set of reproducible "as built" drawings and a final statement of construction costs to the County.

3. **Construction**. Developer shall furnish and construct, at its own expense and in accordance with drawings and materials approved by the County, the improvements described and detailed on Exhibit "B".

4. **Time for Completion**. Improvements shall be completed according to the terms of this agreement within "construction completion date" appearing in Exhibit "B". The Director of Community and Economic Development Department may for good cause grant extension of time for completion of any part or all of improvements appearing on said Exhibit "B". Any extension greater than 180 days may be approved only by the Board of County Commissioners. All extensions of time shall be in written form only.

5. **Warranties of Developer.** Developer warrants that the Improvements shall be installed in good workmanlike manner and in substantial compliance with the Plans and requirements of this Agreement and shall be substantially free of defects in materials and workmanship. These warranties of Developer shall remain in effect until Preliminary Acceptance of the improvements by the County.

6. **Guarantee of Compliance**. Developer shall furnish to the County a cash escrow deposit or other acceptable collateral, releasable only by the County, to guarantee compliance with this agreement. Said collateral shall be in the amount of $<XXXXX>, including twenty percent (20%) to cover administration and five percent (5%) per year for the term of the Agreement to cover inflation. Upon approval of the final plat, completion of said improvements constructed according to the terms of this agreement, and preliminary acceptance by the Director of Public Works in accordance with section 5-02-05-01 of the County's Development Standards and Regulations, the collateral shall be released. Completion of said improvements shall be determined solely by the County, and a reasonable part of said collateral, up to 20%, may be retained to guarantee maintenance of public improvements for a period of one year from the date of preliminary acceptance.

   No building permits shall be issued until said collateral is furnished in the amount required and in a form acceptable to the Board of County Commissioners, and until the final plat has been approved and the improvements described in Exhibit "B" have been preliminarily accepted by the Department of Public Works.

7. **Acceptance and Maintenance of Public Improvements**. All improvements designated "public" on Exhibit "B" shall be public facilities and become the property of the County or other public agencies upon acceptance. During the period of one year from and after the acceptance of public improvements, the Developer shall, at its own expense, make all needed repairs or replacement due to defective materials or workmanship which, in the opinion of the County, becomes necessary. If, within ten days of written notice to the Developer from the County requesting such repairs or replacements, the Developer has not undertaken with due diligence to make the same, the County may make such repairs or replacements at the Developer's expense. In the case of an emergency such written notice may be waived.

8. **Successors and Assigns**. This agreement shall be binding upon the heirs, executors, personal representatives, successors, and assigns of the Developer, and shall be deemed a covenant running with the real property as described in Exhibit "A" attached hereto.

9. **Improvements and Dedication**. The undersigned Developer hereby agrees to provide the following improvements, and to dedicate described property.

A. **Improvements**. Designate separately each public and private improvement.

Public Improvements:

(General description of construction.) See Exhibit "B" for description, estimated quantities and estimated construction costs.

The improvements shall be constructed in accordance with all County requirements and specifications in accordance with the approved plans and time schedule as indicated in Exhibit "B".

B. **Public dedication of land for right-of-way purposes or other public purpose**. Upon approval of this agreement by the Board of County Commissioners, the Developer hereby agrees to convey by warranty deed to the County of Adams the following described land for right-of-way or other public purposes:

(General description of right-of-way).

Name/s
Developer

By: _____
Name, Title

State of Colorado }
} ss:
County of _____ }

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ by _____, as _____ of _____, a _____, on behalf of the _____.

[SEAL]

My Commission Expires: _____ _____
Notary Public

APPROVED BY resolution at the meeting of _____, 20___.

Collateral to guarantee compliance with this agreement and construction of public improvements shall be required in the amount of _____. No building permits shall be issued until said collateral is furnished in the amount required and in a form acceptable to the Board of County Commissioners.

ATTEST:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____
Clerk of the Board

_____
Chair

APPROVED AS TO FORM:

_____
County Attorney

EXHIBIT A
TO DEVELOPMENT AGREEMENT

Legal Description:

EXHIBIT B
TO DEVELOPMENT AGREEMENT

Public Improvements: Street Name/s

Description	Est. Quantity	Est. Unit Cost	Est. Construct. Cost

Construction Completion Date:

Initials or signature of Developer:_____

EXHIBIT C

Table 9 – Summary of Short-Term 2030 and Long-Term 2045 Intersection Improvements

Intersection	Improvements	Project Threshold ADT
Colfax Avenue & Manilla Road	• Construct Eastbound Left Turn Lane (400-ft + 220-ft Taper) * • Construct Westbound Left Turn Lane (770-ft + 220-ft Taper) * • Construct Northbound to Eastbound Acceleration Lane (740-ft + 220-ft Taper) *	• ## • # • 250 ADT
Colfax Avenue & Petterson Road	• Construct Eastbound Left Turn Lane (685-ft + 220-ft Taper) * • Construct Westbound Right Turn Deceleration Lane (380-ft + 220-ft Taper) * • Construct Southbound to Westbound Acceleration Lane (740-ft + 220-ft Taper) *	• 90 ADT NP • 2,050 ADT NP • 496 ADT NP
Colfax Avenue South Parcel West Access	• Construct Eastbound Right Turn Deceleration Lane (380-ft + 220-ft Taper) * • Construct Westbound Left Turn Lane (390-ft + 220-ft Taper) *	• 322 ADT SP • 794 ADT SP
Colfax Avenue South Parcel East Right-in/Right-out Access	• Construct Eastbound Right Turn Deceleration Lane (380-ft + 220-ft Taper) *	• 642 ADT SP
I-70 Westbound Ramps & Manilla Rd	• Construct Southbound Right Turn Lane (275-ft + 160-ft Taper) • Construct Westbound Right Turn Lane (100-ft + 160-ft Taper) * • Traffic Signal	• # • 682 ADT • ###
I-70 Eastbound Ramps & Manilla Rd	• Construct Eastbound Left Turn Lane (275-ft + 160-ft Taper) *	• #

Improvement Warranted Based on Existing Traffic;
Improvement Not Related to Project;
= Long Term Improvement Not Needed with Full Project Development
* = These improvements are within CDOT jurisdiction and will be either funded or constructed as required by CDOT. County will advise developer if an access permit triggers these improvements.
NP = North Parcel; SP = South Parcel;
Notes:

- The timing of the City of Aurora improvements will be in accordance with Aurora requirements.
- The County and Developer acknowledge that fair share reimbursement is allowed for required offsite County improvements in accordance with the Adams County Development Standards and Regulations, Section 5-02-04. Reimbursement may be provided for in the Development Agreements pursuant to this Master Agreement.
- All improvements needed by near-term study horizon 2030 other than signalization of the I-70 WB Ramp which was found to be needed by 2045.

Commenting Division: Planner Review

Name of Reviewer: Nick Eagleson

Date: 11/20/2019

Email:

Resubmittal required

PLN01: County staff, the applicant, and the FAA should work together on some sort of future access to the CASP. This should be spelled out in the SIA.
PLN02: Submit SIA with your next resubmittal.
PLN03: An agreement will need to be in place prior to approval of the Final Plat and FDP for the section of track at the southwest corner of the site, which currently travels through County owned property.
PLN04: Parkland dedication fees have been calculated and total $1,539,797.84. See attached .pdf for calculation. There is the potential to dedicate land for a regional park at a minimum of 50 acres, which can be non-contiguous to the site. However, the BOCC decides whether cash-in-lieu or land dedication is most appropriate. You can also have the land appraised to see if the assessed value comes in under the $49,715/acre assessed by the County. The payments can also be phased, per section 5-05-05-03 from the Adams County Development Standards. This should be included as part of the SIA.
PLN05: A certificate of taxes paid from the County Treasurer's office is required.
PLN06: Is there still a walking path/trail located around the perimeter of the site?
PLN07: Please coordinate a meeting between yourself, the City of Aurora, and Adams County to discuss infrastructure needs.

Final Plat:
PLN08: The plat does not appear to be consistent and does not conform to the approved preliminary plat.
PLN09: The plat is in conformance with the subdivision design standards
PLN10: Evidence of sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards. The Colorado Division of Water resources acknowledged there is no concern.
PLN11: The applicant has provided evidence that adequate sewage disposal will be provided and complies with state and local laws and regulations.
PLN12: The applicant has provided evidence that the proposed uses of the areas are compatible with the soil or topographical conditions.
PLN13: The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
PLN14: Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision will either be constructed, or financially guaranteed through cash-in-lieu or a subdivision improvement agreement so the proposed subdivision will not negatively impact the levels of service of the County.

Final Development Plan:
PLN15: Remove the signature block titled “Staff Review.”
PLN16: The FDP is in general conformity with the Adams County Comprehensive Plan and any applicable area plan.
PLN17: The FDP conforms to the PUD standards.
PLN18: The FDP is consistent with the approved PDP.

PLN19: The FDP construction plans meet the requirements of these standards and regulations and have been approved by the Director of Community and Economic Development, all infrastructure and utility providers, Tri-County Health Department, and all other referral agencies.

Commenting Division: Environmental Analyst Review

Name of Reviewer: Katie Keefe

Date: 11/19/2019

Email:

Resubmittal Required

ENV1. Due to the proximity of the parcels to Denver International Airport (DIA), they are covered by the Airport Height Overlay (AHO), which restricts some building height and certain development. More information can be found in Section 3-32 of the Adams County Development Standards and Regulations.

- Landowners may be required to install, operate, and maintain, at the owner's expense, such markers and lights which may be necessary to indicate to flyers the presence of a hazard which affects the aviation facility. This marking and lighting requirement may also extend to objects of natural growth (trees, primarily) on site. (3-32-04-03 LANDOWNERS TO INSTALL MARKERS)
- An FAA aeronautical study may be required to determine if the proposed development could be a hazard to air navigation. (3-32-04-01 PROPOSED DEVELOPMENT TO COMPLETE AERONAUTICAL STUDY)

ENV2. Due to the proximity of the parcels to Front Range Airport, it is covered by the Airport Noise Overlay (ANO). The portions of the commercial or industrial structures devoted to office uses, or occupied by members of the public must incorporate noise level reduction measures sufficient to achieve an interior noise level of 45 dB on the A-weighted scale.

ENV3: If fill material will be imported to the site for site development, the applicant must obtain a temporary use permit for inert fill operations. The applicant shall provide details of the source material certifying that all fill material brought onsite is clean. This may be satisfied by submitting a signed letter from the owner of the fill certifying that it is clean, providing a due diligence report demonstrating no recognized environmental concerns are associated with the source site, or providing results of a soils test following guidance provided by the Department. Please contact kkeefe@adcogov.org for more information on soils sampling plans and required analysis if a soils test is performed.

Commenting Division: ROW Review

Name of Reviewer: Marissa Hillje

Date: 11/19/2019

Email: mhillje@adcogov.org

Resubmittal Required

ROW1. Submit a title commitment which should be used to depict the applicable recordings on the plat. Send Adams County a copy of the title commitment with your application dated no later than 30 days to review in order to ensure that any other party's interests are not encroached upon.
ROW2. Incorporate this language into Note 11: "By this plat, a tract is created for use by the owners of the lots for access onto Picadilly Road and E 48th Ave. The construction and maintenance of a private road within the Tract A is the full and complete responsibility of the property owner(s) of the subdivision, in perpetuity. Adams County assumes no responsibility or liability regarding the private road, and will not perform maintenance operations including snow removal."
ROW3. See redlines for labels needed for the private road.
ROW4. Edit the Legal description- see redlines
ROW5. The Tract table is different than the preliminary plat. Add Access in the use portion where applicable. This plat is not a conveyance document- clarify what the dedication column is meant for.

ROW6. The Right-of-way dedication to City of Aurora should be done prior to the approval of this plat. It can be done if there is a condition placed on the approval. The City of Aurora usually does not sign plats as it is usually dedicated by deed. The County will need verification from City of Aurora on how they would like it to be done. The county will work with developer on timing and how it should be shown on the plat.

ROW7. LOT 1 is shown different on this plat than the prelim. The County suggest editing lot 1 and creating a tract for the rail portion- see redlines.

ROW8. Is there any lots/tracts that are specifically drainage? The table is not specific. The county needs to make sure that there is drainage detention pond delineated on the plat as well as access to the pond

ROW9. The 60ft access easement on Lot 11- what is this for? Is there a private road there?

ROW10. The public access easement can be dedicated by the plat- specific language should be added to the notes section on what the access is for- who can use it and who will maintain it.

ROW11. See redlines on plat attached. Additional redline comments may be needed on next submittal.

Commenting Division: Development Engineering Review

Name of Reviewer: Matthew Emmens

Date: 11/13/2019

Email: memmens@adcogov.org

Resubmittal Required

Review complete with comments. Resubmittal required. See doc #6004789.

Commenting Division: Addressing Review

Name of Reviewer: Marissa Hillje

Date: 11/13/2019

Email: mhillje@adcogov.org

Resubmittal Required

Each lot being created shall have an address. Addresses can be assigned on the plat.

PRC2019—00012
Rocky Mountain Rail Partners
Engineering Review Comments

ENG1: Flood Insurance Rate Map – FIRM Panel # (08001C0695H), Federal Emergency Management Agency, January 20, 2016. According to the above reference, the project site is NOT located within a delineated 100-year flood hazard zone; a floodplain use permit will not be required.

ENG2: LOW IMPACT DEVELOPMENT (LID) STANDARDS AND REQUIREMENTS Section 9-01-03-14:
All construction projects shall reduce drainage impacts to the maximum extent practicable, and implement practices such as:

1. On-site structural and non-structural BMPs to promote infiltration, evapo-transpiration or use of stormwater,
2. Minimization of Directly Connected Impervious Area (MDCIA),
3. Green Infrastructure (GI),
4. Preservation of natural drainage systems that result in the infiltration, evapo-transpiration or use of stormwater in order to protect water quality and aquatic habitat.
5. Use of vegetation, soils, and roots to slow and filter stormwater runoff.
6. Management of stormwater as a resource rather than a waste product by creating functional, attractive, and environmentally friendly developments.
7. Treatment of stormwater flows as close to the impervious area as possible.

LID shall be designed and maintained to meet the standards of these Regulations and the Urban Drainage and Flood Control District's Urban Storm Drainage Criteria Manual, Volume 3.

ENG3: Sustainable Development Practices Section **3-27-06-05-07-08:**
To the maximum extent practicable, new buildings are encouraged to incorporate one or more of the following features:

1. Opportunities for the integration of renewable energy features in the design of buildings or sites, such as: solar, wind, geothermal, biomass, or low-impact hydro sources;
2. Energy-efficient materials, including recycled materials that meet the requirements of these regulations;
3. Materials that are produced from renewable resources;
4. Low-Impact Development (LID) stormwater management features;
5. A green roof, such as a vegetated roof, or a cool roof;
6. Materials and design meeting the U.S. Green Building Council's LEED-NC certification requirements;
7. A greywater recycling system.

ENG4: The applicant shall be responsible to ensure compliance with all Federal, State, and Local water quality construction requirements. The project site is not within the County's MS4 Stormwater Permit area; an Adams County Stormwater Quality Permit (SWQ) is NOT required. The installation of erosion and sediment control BMPs are expected.

ENG5: Prior to scheduling the final plat/FDP BOCC hearing, the developer is required to submit for review and receive approval of all construction documents (construction plans and reports). Construction documents shall include, at a minimum, onsite and public improvements construction

plans, drainage report, traffic impact study. All construction documents must meet the requirements of the Adams County Development Standards and Regulations. The developer shall submit to the Adams County Development Review Engineering division the following: Engineering Review Application, Engineering Review Fee, two (2) copies of all construction documents. The development review fee for an Engineering Review is dependent on the type of project and/or the size of the project. The Development Review fee can be found in the Development Services Fee Schedule, located on the following web page: http://www.adcogov.org/one-stop-customer-center.

The applicant has submitted construction drawings for review. The Construction documents are not approved at this time.

ENG6: The developer is required to construct roadway improvements adjacent to the proposed site. Roadway improvements will consist of curb, gutter and sidewalk adjacent to the site and, any roadway improvements as required by the approved traffic impact study.

ENG7: Prior to the issuance of any construction or building permits, the developer shall enter into a Subdivision Improvements Agreement (SIA) with the County and provide a security bond for all public improvements.

ENG8: No building permits will be issued until all public improvements have been constructed, inspected and preliminarily accepted by the County's Transportation Dept.

ENG9: The developer is responsible for the repair or replacement of any broken or damaged County infrastructure.

ENG10: The applicant is proposing to phase construction of this development and the required public improvements. The phasing schedule should be included on the Final Development Plan (FDP). The phasing schedule should be based on the need for the specific improvements as the site is development and, clearly outlined in the FDP. When/if the FDP is approved, the applicant will be strictly held to the phasing schedule.

ENG11: Section 5-02-03 of the Adams County Development Standards and Regulations (DSR) specifically states:

> No portion or phase of a subdivision will be granted Preliminary Acceptance until all items identified in the Subdivision Improvements Agreement have been completed. Construction phasing will not be permitted for the purposes of partial acceptance. If the subdivider desires to improve smaller portions of the subdivision, they shall be submitted for review and recorded as individual filings.

The phasing schedule will need to be included in the SIA for this development and meet the requirements of this Section or, the applicant will be required to apply for a waiver to the Chapter 5 subdivision design standards.

ENG12: The preliminary Traffic Impact Study showed necessary offsite roadway improvements between the site and the I-70 interchange. And, the existing condition of the asphalt in Manilla Rd, Pederson Rd and possibly Colfax Ave will not support heavy truck traffic or a significant increase in standard vehicle traffic. The FDP and final plat construction need to address these deficiencies as the current roadway network cannot support this development. The applicant will be required to improvement these

roadways to support this development. This issue needs to be addressed and resolved prior to scheduling the FDP/Final Plat hearings.

ENG13: Applicant is required to coordinate all public transportation improvements with the City of Aurora and the Transport Colorado development. Applicant shall schedule and attend meetings with the City and Adams County staff and, incorporate all necessary revisions into the Rocky Mountain Rail Park construction documents.

Additional Engineering Comments:

1. The applicant will need to submit a phasing plan for this development. That plan will need to show the overall development with all required public improvements and, what the triggers for those improvements will be.
    a. Upon receipt of that plan, County staff can review and comment on the phasing triggers.
    b. Once the phasing and phasing triggers are approved by the County, the applicant will be required to include the phasing plan on the P.U.D.
2. In order to allow phasing of the development and public improvements, the applicant will need plat the site with individual filings for each phase.
    a. The individual filings can create a single or multiple lots.
    b. Each individual filing will need to include the required public improvements based on the phasing plan contained in the PUD (as included with the Final Development Plan), as well as any other improvements that come to light during review of the individual filing.
3. The applicants first filing/phase is required to include:
    a. All of the perimeter landscaping, berming and, trail shown on the PDP.
4. The applicant is required to include all available traffic count information and drainage design information from the Transport Colorado development, located in the City of Aurora, into their design studies and construction plans.
    a. Coordination of the traffic and drainage data is to be done through the City of Aurora in collaboration with Adams County.
    a. Applicants public improvement plans are required to anticipate, to the extent possible, any future public improvements required for the Transport Colorado development.
5. The applicant is required to have the roadway sections for Pederson Rd and Manilla Rd analyzed for structural capacity.
    a. The applicant will be required to improve the roadway sections of Pederson Rd and Manilla road to handle the traffic loading (i.e. trucks) anticipated in the Traffic Impact Study.
6. The applicant is required to coordinate all required roadway improvement to Colfax Ave with the Colorado Department of Transportation.

From:	Gordon Stevens
To:	Nick Eagleson
Cc:	David Rausch; Russell Nelson; Monica Lovato-Ramirez; Juliana J. Archuleta
Subject:	RE: For Review: Rocky Mountain Rail Park (PRC2019-00012)
Date:	Friday, October 25, 2019 1:37:24 PM
Attachments:	DOCS-#5998555-v1-SUBMITTAL__ROCKY_MOUNTAIN_RAIL_PARK__48TH_AVE__AND_PETERSON_RD___SITE_APPLICATION.PDF

Good Morning Nick,

Thank you for the opportunity to review this submittal. The Adams County Dept. of Public Works, Infrastructure Management, Construction Inspection Division offers the following comments:

1. A Subdivision Improvement Agreement (SIA) and related collateral will be required for the construction of all Public Facilities as they relate to this subdivision construction. This agreement will have to be approved by the BoCC.
2. The Development Standards and Regulations are very clear on the construction of public roadways and perimeter roadways. As this proposed subdivision borders both Peterson Rd. and 48th Ave., this SIA will be specifically written for the improvements along these roadways. Other roadways may be involved as well, as additional requirements are flushed out with this application.
3. It is very possible that the City of Aurora may want some improvements along their jurisdictional boundary as well.
4. It is possible that the City of Aurora may require annexation if the site is to be served by Aurora Utilities.
5. Construction plans must be submitted and approved prior to the beginning of construction.
6. A pre-construction meeting must be held prior to construction.
7. No Building Permits/CO's can be issued until all Public Improvements have been installed and have received Preliminary Acceptance from the Adams County Department of Public Works.
8. A construction Permit cannot be issued until all construction plans have been reviewed and approved, and the Subdivision Improvement Agreement has been approved by the Adams County BoCC.

Again, thank you for the opportunity to review this submittal. If I can be of any further assistance, please do not hesitate to contact me at any time. This referral has also been submitted to other staff members of the Department of Public Works for further review.

Sincerely,

Gordon Stevens
Construction Inspection Supervisor,
Department of Public Works
Infrastructure Management Division
ADAMS COUNTY, COLORADO

COLORADO
Division of Water Resources
Department of Natural Resources
Colorado Ground Water Commission

April 18, 2019

Greg Barnes
Adams County Community & Economic Development Department
Transmitted via email:
GJBarnes@adcogov.com

RE: Rocky Mountain Rail Park Subdivision (PRC2018-00006)
Part of the E1/2 of Sections 23, 26, and NE1/4 of Section 35, T3S, R64W, 6th P.M.,
Lost Creek Designated Ground Water Basin
Water Division 1, Water District 1

Dear Mr. Barnes:

We have reviewed your March 26, 2019 submittal concerning the above referenced proposal to subdivide approximately 620 acres of land into 11 lots (and "various tracts") for an industrial park. This office previously commented on the proposal in a letters dated June 26, 2018, July 31, 2018, September 20, 2018, November 14, 2018 and January 3, 2019.

Water Supply Demand

A Technical Memorandum by FEI Engineers dated May 22, 2018 estimates the water demand for this subdivision is 49.46 AF/yr of potable water, 101.39 AF/yr of non-potable irrigation water and 0.552 AF/yr of potable fire suppression water, for a total estimated water demand of 151.4 AF/yr.

Source of Water Supply

The proposed water supplier is the Rocky Mountain Rail Park Metropolitan District ("District"). The new information submitted indicates the District was approved by the Board of the County Commissioners and in the November election and the order by Adams County District Court approving the District is awaiting approval. The District's proposed sources of water are the Denver Basin bedrock aquifers. The submittal indicates that the Determination of Water Rights nos. 3625-BD, 3626-BD, 3627-BD and 3628-BD is the proposed source of water for the District. The applicant has submitted draft deeds for transferring the water rights from Rail Land Company, LLC to the District once the District has officially been formed. The District's boundaries are the 620 acres associated with the Determination of Water Rights nos. 3625-BD, 3626-BD, 3627-BD and 3628-BD and the District will have no additional commitments beside the commitments for this subdivision.

Determination of Water Rights nos. 3625-BD, 3626-BD, 3627-BD and 3628-BD were issued for the Laramie-Fox Hills, Lower Arapahoe, Upper Arapahoe, and Denver aquifers respectively underlying the 620 acre property to Rail Land Company, LLC for the uses of domestic, livestock watering, irrigation, commercial, replacement, recreation, industrial, mechanical and fire protection.

Table 1 below shows the amount of water in the Determination of Water Rights for a 100 year and 300 year allocation approach.

Table 1

Aquifer	Determination of Water Right	Based on 100 year allocation approach	Based on 300 year allocation approach
Denver (NNT 4%)	3628-BD	208.6	69.53
Upper Arapahoe (NT)	3627-BD	105.3	35.1
Lower Arapahoe (NT)	3626-BD	52.8	17.6
Laramie-Fox Hills (NT)	3625-BD	142.8	47.6
Total		509.5	169.83

In the Adams County Development Standards and Regulations, Effective April 15, 2002, Section 5-04-05-06-04 states:

"Prior to platting, the developer shall demonstrate that…the water supply is dependable in quantity and quality based on a minimum useful life of three-hundred (300) years. A minimum 300-year useful life means the water supply from both a static and dynamic basis will be viable for a minimum 300-year period. The static analysis shall include evaluation of the volume of water that is appropriable for the proposed subdivision. The dynamic analysis shall evaluate whether the appropriable water supply is sustainable for three-hundred (300) years, giving consideration to the location and extent of the aquifer, as well as impacts caused by both current and future pumping by others from the aquifer."

The State Engineer's Office does not have evidence regarding the length of time for which this source will be "dependable in quantity and quality." However, treating Adam County's requirement as an allocation approach based on three hundred years, the allowed average annual amount of withdrawal of 509.5 acre-feet/year would be reduced to one third of that amount, or 169.83 acre-feet/year. The State Engineer's Office has no comment on the quality of the water supply or the required 'dynamic analysis' to evaluate whether the appropriable water supply is sustainable for three hundred years.

State Engineer's Office Opinion

Based upon the above and pursuant to Section 30-28-136(1)(h)(I) and Section 30-28-136(1)(h)(II), C.R.S., it is our opinion that the proposed water supply is adequate and can be provided without causing injury to decreed water rights **on the condition the District is formed, the Determination of Water Rights Nos. 3625-BD, 3626-BD, 3627-BD and 3628-BD are transferred to the District as described in the referral information and a written commitment of service from the District be provided referencing the name of the subdivision as submitted to the county and a level of commitment in terms of uses to be served and/or water requirement.**

Our opinion that the water supply is adequate is based on our determination that the amount of water required annually to serve the subdivision is currently physically available, based on current estimated aquifer conditions.

Our opinion that the water supply can be provided without causing injury is based on our determination that the amount of water that is legally available on an annual basis, according

to the statutory allocation approach, for the proposed uses on the subdivided land is greater than the annual amount of water required to supply existing water commitments and the demands of the proposed subdivision.

Our opinion is qualified by the following:

The Ground Water Commission has retained jurisdiction over the final amount of water available pursuant to the above-referenced decree, pending actual geophysical data from the aquifer.

The amounts of water in the Denver Basin aquifer, and identified in this letter, are calculated based on estimated current aquifer conditions. For planning purposes the county should be aware that the economic life of a water supply based on wells in a given Denver Basin aquifer may be less than the 100 (or 300) years used for allocation due to anticipated water level declines. We recommend that the county determine whether it is appropriate to require development of renewable water resources for this subdivision to provide for a long-term water supply.

Should you or the applicant have any questions, please contact Ailis Thyne at (303) 866-3581 x8216.

Sincerely,

Keith Vander Horst

Keith Vander Horst, P.E.
Chief of Water Supply, Basins

KVH/AAT

COLORADO GEOLOGICAL SURVEY

1801 19th Street
Golden, Colorado 80401

Karen Berry
State Geologist

June 22, 2018

Greg Barnes
Adams County Community and Economic Development
4430 S. Adams County Parkway, Suite W2000A
Brighton, CO 80601-8216

Location:
E½ Sections 23 and 26,
and NE¼ Section 35,
T3S, R64W, 6th P.M.
39.7674, -104.5126

Subject: Rocky Mountain Rail Park
Comp Plan Amendment, Rezoning to PUD, Major Subdivision Preliminary Plat, and PDP
Case Number PRC2018-00006; Adams County, CO; CGS Unique No. AD-18-0016

Dear Mr. Barnes:

Colorado Geological Survey has reviewed the Rocky Mountain Rail Park referral. I understand the applicant proposes eleven industrial and commercial lots with rail access on approximately 620 acres located west of Peterson Road, north and south of Colfax, east of Front Range Airport. With this referral we received a request for CGS's review (May 24, 2018), a Project Explanation (Enertia Consulting Group, May 24, 2018), sheets 1 and 2 of the PUD plans (Enertia, May 23, 2018), and a site plan sheet for the Comprehensive Plan Amendment, Subdivision-Major/Preliminary, and Zoning Map Amendment applications (Enertia, May 22, 2018). We understand a new metro district will be created for water and sanitation.

The site does not contain, nor is it exposed to, any geologic hazards that would preclude the proposed industrial/commercial uses and density. **CGS therefore has no objection to approval of eleven-lot subdivision as proposed.**

Mineral resource potential. According to the Atlas of Sand, Gravel, and Quarry Aggregate Resources, Colorado Front Range Counties (Schwochow et al, Colorado Geological Survey Special Publication 5-B, 1974, Manila Quadrangle), the property is **not** mapped as containing a sand, gravel, or aggregate resource. Approximately the southwestern one-third of the site is located within the northeastern area of the Watkins lignite seam as mapped in Kirkham, R.M., 1978, The Watkins Lignite Seam, Adams and Arapahoe Counties, Colorado: Colorado Geological Survey, Open-File Report OF-78-6, scale 1:50,000. The maximum thickness of the lignite seam is approximately 20 feet at the southeastern corner of the property, pinches out toward the northeast, and ranges from approximately 60 to 100 feet below the ground surface. Since the Union Pacific corridor crosses this portion of the site, and the lignite is at a relatively shallow depth where extraction would almost certainly cause subsidence damage at the surface, it is highly unlikely that the lignite would ever be mined. However, a determination regarding whether lignite in general, or this lignite seam specifically, constitutes an economically viable mineral resource is outside the scope of CGS review.

Soil/bedrock engineering properties. According to available geologic mapping, the site is underlain by wind-deposited fine sands, silt and clay. Wind-deposited soils, especially those containing soluble calcareous minerals, tend to be loose, fine-grained, and compressible/hydrocompactive, meaning they can lose strength, settle, compress, or collapse under a structural load and/or when water infiltrates the deposits. Thick columns of compressible or collapsible soils can result in very significant settlement and structural damage. Depending on their clay content, these soils can also exhibit shrink/swell (volume changes in response to changes in water content).

Site-specific geotechnical investigations and analysis will be needed, once building locations are identified on each lot, to determine depths to bedrock and seasonal groundwater levels, and to characterize soil and bedrock engineering properties such as density, strength, and swell/consolidation potential for use in design of foundations, floor systems, subsurface drainage, and pavements.

Thank you for the opportunity to review and comment on this project. If you have questions or require additional review, please call me at (303) 384-2643, or e-mail carlson@mines.edu.

Sincerely,

Jill Carlson, C.E.G.
Engineering Geologist

Right of Way & Permits

1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571.3284
donna.l.george@xcelenergy.com

November 8, 2019

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Nick Eagleson

Re: Rocky Mountain Rail Park Final Plat, Case # PRC2019-00012

Public Service Company of Colorado's (PSCo) Right of Way & Permits Referral Desk has reviewed the final plat for **Rocky Mountain Rail Park** and again requests, to ensure that adequate utility easements are available within this development, that the following language or plat note is placed on the preliminary and final plats for the subdivision:

> *Minimum ten-foot (10') wide dry utility easements are hereby dedicated on private property abutting all public streets, and around the perimeter of each commercial/industrial lot in the subdivision or platted area including tracts, parcels and/or open space areas. These easements are dedicated to Adams County for the benefit of the applicable utility providers for the installation, maintenance, and replacement of electric, gas, television, cable, and telecommunications facilities (Dry Utilities). Utility easements shall also be granted within any access easements and private streets in the subdivision. Permanent structures, improvements, objects, buildings, wells, and other objects that may interfere with the utility facilities or use thereof (Interfering Objects) shall not be permitted within said utility easements and the utility providers, as grantees, may remove any Interfering Objects at no cost to such grantees, including, without limitation, vegetation. Public Service Company of Colorado (PSCo) and its successors reserve the right to require additional easements and to require the property owner to grant PSCo an easement on its standard form.*

PSCo also requests that the tracts are dedicated for utility use for crossings.

Public Service Company also requests that **all utility easements be depicted graphically on the preliminary and final plats**. While these easements may accommodate certain utilities to be installed in the subdivision, some additional easements may be required as planning and building progresses.

Please be aware PSCo owns and operates existing overhead electric distribution facilities within the subject property. The property owner/developer/contractor must complete the application process for any new natural gas or electric service, or modification to existing facilities via

xcelenergy.com/InstallAndConnect. It is then the responsibility of the developer to contact the Designer assigned to the project for approval of design details. Additional easements may need to be acquired by separate document for new facilities.

As a safety precaution, PSCo would like to remind the developer to call the Utility Notification Center by dialing 811 for utility locates prior to construction.

Donna George
Right of Way and Permits
Public Service Company of Colorado dba Xcel Energy
Office: 303-571-3306 – Email: donna.l.george@xcelenergy.com

November 13, 2019

Nick Eagleson
Adams County Community and Economic Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601

RE: Rocky Mountain Rail Park, PRC2019-00012
TCHD Case No. 5940 & 5941

Dear Mr. Eagleson,

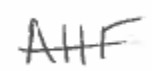
Thank you for the opportunity to review and comment on the Final Plat to create 11 lots and 11 tracts and Final Development Plan to establish the Rocky Mountain Rail Park Planned Unit Development on 620 acres located at the northwest corner of Petterson and Colfax. Tri-County Health Department (TCHD) staff has reviewed the application for compliance with applicable environmental and public health regulations and principles of healthy community design. After reviewing the application, TCHD has the following comments.

Wastewater Treatment
Proper wastewater management promotes effective and responsible water use, protects potable water from contaminants, and provides appropriate collection, treatment, and disposal of waste, which protects public health and the environment. The application states that the site will be self-sufficient by supplying its own sanitary treatment plant. Domestic Wastewater Treatment Works (DWWTW) are regulated by the Colorado Department of Public Health and Environment (CDPHE). CDPHE requires site approval, a discharge permit, and design approval for all DWWTW. It is our understanding that the DWWTW is not yet approved and CDPHE sent a Request for Information on February 20, 2019. The applicant should contact the CDPHE Water Quality Control Division regarding the DWWTW. Until the DWWTW is approved, TCHD cannot provide a favorable recommendation. More information can be found here: https://www.colorado.gov/pacific/cdphe/clean-water-site-wastewater-treatment-systems.

Public Water System
Systems serving 25 or more persons on average, a minimum of 60 days per year are subject to regulation by the Colorado Department of Public Health and Environment (CDPHE) as a non-community drinking water system. The applicant shall contact the CDPHE Drinking Water Section at (303) 692-3500 or https://www.colorado.gov/pacific/cdphe/drinking-water to determine requirements for the drinking water system.

Please feel free to contact me at 720-200-1585 or aheinrich@tchd.org if you have any questions.

Sincerely,



Annemarie Heinrich Fortune, MPH/MURP
Land Use and Built Environment Specialist

cc: Sheila Lynch, Monte Deatrich, Warren Brown, TCHD
Jeffrey Hlad, CDPHE

MEMORANDUM

TO: Nick Eagleson and Adams County Planning Commission Members

FROM: Richard R. Follmer, PE, PTOE
Felsburg Holt & Ullevig
6300 S. Syracuse Way, Suite 600
Centennial, CO 80111

DATE: November 11, 2019

SUBJECT: Rocky Mountain Rail Park

Members of the Planning Commission, I am writing this memorandum to you to express a concern I have related to the development of the Rocky Mountain Rail Park. As information, I am the project manager for preparation of the Traffic Impact Analysis (TIA) for Transport Colorado, a project that is directly adjacent to the Rocky Mountain Rail Park and to the Colorado Air and Space Port.

The *Transport Colorado TIA* has been reviewed by the City of Aurora for Preliminary Development Plan approval and a revised TIA will be submitted to the City for a second review shortly. As such, I have some knowledge of existing and future roadway and traffic conditions in this area. And as you know, the *Northeast Area Transportation Study* (*NEATS*) *Refresh* study was completed in October 2018 for which Adams County was a part of the Technical Working Group. *NEATS Refresh* conducted an exhaustive evaluation of traffic projections and it identified roadway, transit, and bicycle/pedestrian facilities to meet the projected development estimates.

My concern regarding the *Rocky Mountain Rail Park Traffic Impact Study* (*TIS*) is that it does not address the *NEATS Refresh* traffic projections in their estimates of background traffic growth. Their traffic study uses 20-year projected growth rates along US 36 (Colfax Avenue) from the Colorado Department of Transportation (CDOT) that does not reflect the intensity of development that is expected to occur within Transport Colorado and for projects that *NEATS Refresh* evaluated. As such, when Rocky Mountain Rail Park predicts good intersection operations, particularly for the Year 2040, those operational conditions may be overly optimistic when you consider the influence of other projects that will develop within the same timeframe.

Relative to roadway infrastructure improvements, *NEATS Refresh* recommends the widening of Manila Road to four through lanes, something that is not addressed in the *Rocky Mountain Rail Park TIS*. Additionally, while not specifically identified in *NEATS Refresh*, improvements to the I-70/Manila Road interchange will also be required, particularly to accommodate large vehicle movements.

Bearing in mind the information above, it is requested that the Adams County Planning Commission consider a more thorough evaluation of traffic projections, their impacts, and recommended infrastructure improvements that the Rocky Mountain Rail Park should be a partner in.

Thank you for your consideration on this matter.

November 13, 2019

MEMORANDUM

Nick Eagleson – and Adams County Planning Commission Members

Re: Referral Response to the Request that Rocky Mountain Rail Park

On behalf of Transport Colorado, LLC ("Transport"), a 6500-acre industrial and logistics park with real estate holdings east and west of the proposed Rocky Mountain Rail Park (RMRP). More specifically this letter concerns Subarea 1 of Transport, which is 1154 acres of Heavy Rail Served Industrial Park in close proximity to RMRP. We are writing to request that Adams County assist the Applicants of RMRP and Transport Colorado in establishing appropriate cost sharing levels related to public improvements together that are proportionate to their respective development impacts to existing infrastructure in the area. We see impacts to the area relative to each of these rail served industrial developments specifically 1154 acres for Transport (Subarea 1) and 620 acres for RMRP.

We certainly recognize RMRP has followed all the regulations required by Adams County and is a good project. Furthermore, we are not objecting to the RMRP project as was stated in July 2019, but there are many impacts to consider based on both projects developing over the next 18-24 months. It is our estimate that between the Transport and RMRP projects thousands of jobs will be created in Adams County and Aurora. As a result, the current infrastructure will not support those impacts without substantial improvements.

The discussion points made with the Adams County Board of Commissioners at the July 2019 hearing was as follows:

A. RMRP and Transport should consider sharing costs of traffic impacts on existing infrastructure, such as Manilla Road and the Manilla Road Interchange. Even though they have staggered development schedules, both projects will generate traffic and trigger drainage, road and interchange improvements.

B. Utility services are nonexistent in this area. Both projects should consider sharing costs for sewer and water in the area.

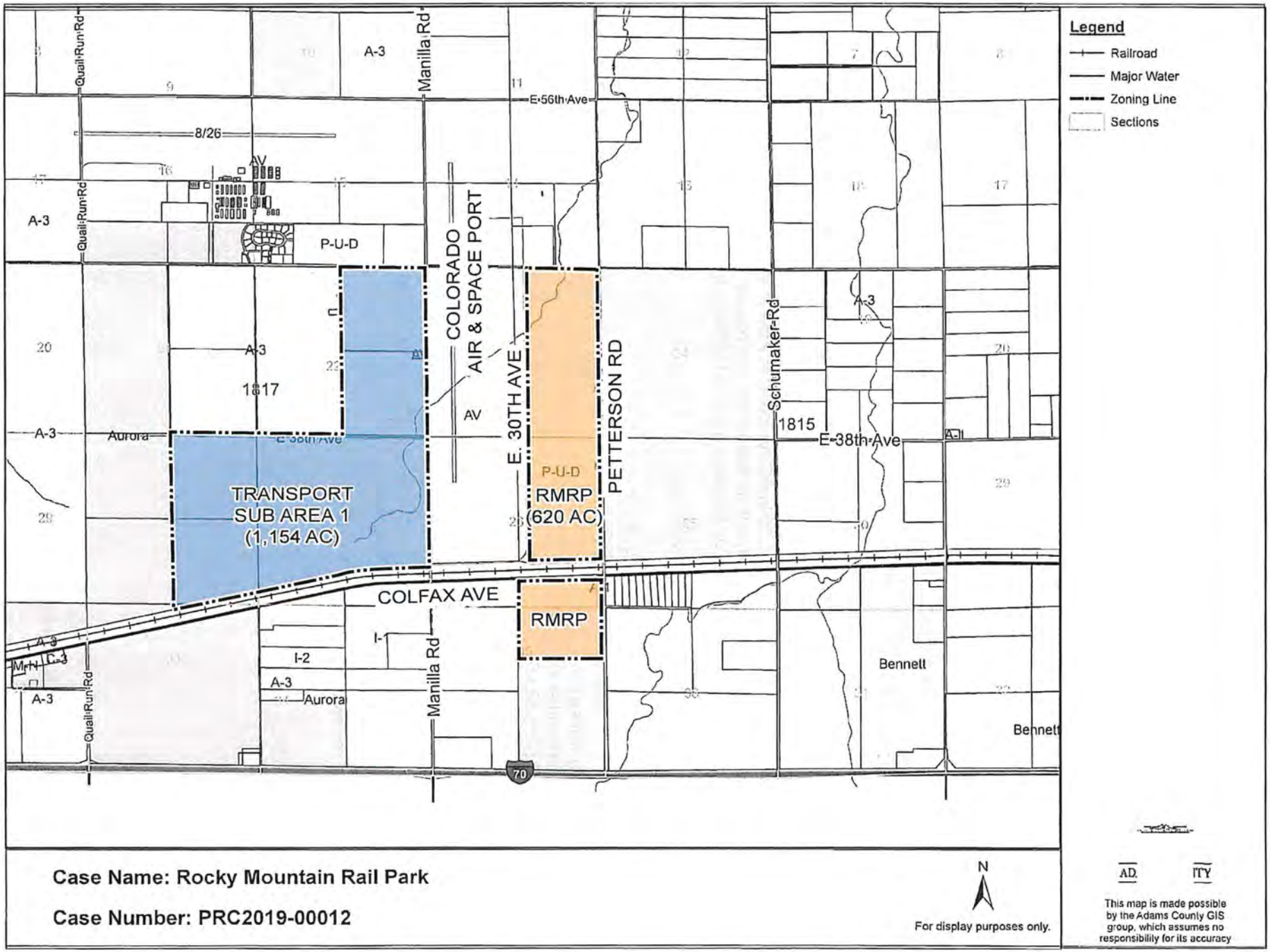
C. Health, Safety and Welfare services (Fire / Police Annex) are nonexistent in the area and these costs should also be shared.

Because infrastructure funding decisions are made and guided by local government, we respectfully request that Adams County schedule a work session together with the City of Aurora, the RMRR applicants and Transport Colorado to establish infrastructure cost sharing obligations for the respective developments. Again, both projects will be wonderful additions to the community (Adams County & Aurora) and their success will be predicated on all parties working together to formulate a plan that benefits the collective stake holders.

Thank you for your consideration,

Kenneth J. Puncerelli

Kenneth J. Puncerelli, CEO


Legend
Railroad
Major Water
Zoning Line
Sections
Quail Run Rd
Manilla Rd
E 56th Ave
8/26
A-3
P-U-D
COLORADO AIR & SPACE PORT
E. 30TH AVE
PETTERSON RD
Schumaker Rd
1817
1815
Aurora
E 38th Ave
TRANSPORT SUB AREA 1 (1,154 AC)
RMRP (620 AC)
RMRP
COLFAX AVE
I-2
I-1
Bennett
70
Case Name: Rocky Mountain Rail Park
Case Number: PRC2019-00012
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For display purposes only.
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This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

TRANSPORT COLORADO
LOGISTICS & COMMERCE PARK

Kelsey B. Hall
Land & Project Manager
TransPort Colorado, LLC
Office: 720-547-9781 ext 105
KHall@TransPortColorado.com

November 14, 2019

Nick Eagleson
Planner III, Community and Economic Development Dept.
4430 S. Adams County Parkway, 1st Floor, Suite W2000A
Brighton, CO 80601-8216

RE: Rocky Mountain Rail Park Project ("RMRP")
PRC2019-00012

Nick,

I, Kelsey Hall, am the Land & Project Manager at TransPort Colorado, LLC. TransPort Colorado is a ~6,500-acre mixed-use commerce park located within Adams County and neighbors the proposed RMRP Project on its eastern and western boundaries.

During the Planning Commission Meeting held on June 13th, 2019 and the Board of County Commissioners Meeting on June 18th, 2019, TransPort Colorado raised numerous concerns with respect to the regional impact of the RMRP Project, in which the RMRP Project was conditionally approved. TransPort Colorado is providing comment again today not in opposition of the proposed industrial park by RMRP, however, is requesting a perpetual continuance of any further hearings until such date that RMRP has appropriately addressed all the affected stakeholders' concerns.

To that point, TransPort Colorado's 1,154-acre rail-served industrial park, reference maps attached, is directly affected by the RMRP Project. This park is currently in its development stages with the City of Aurora ("the City") in which the Master Framework Development Plan along with two Sub-Area Master Development Plans have been submitted for review and approval. The 1,154-acre rail-served industrial park (Sub Area #1) in this submittal utilizes similar routing between I-70 and Colfax on Manila Road. In review of RMRPs Final Development Plan, TransPort Colorado has differing results as to what extent improvements need to be made for development use in the City and Adams County, which is supported by its own traffic impact analysis previously provided to Adams County.

We find it imperative that all stakeholders, to include the City, Adams County, TransPort Colorado and RMRP, coordinate all major infrastructure with respect to reasonable cost sharing of near and medium term construction in order for both projects to be successful for the benefit of the City and Adams County. At a minimum, all affected stakeholders need to find common ground on the following list of comments from the City prior to approval of the RMRP Project.

- The Traffic Impact Analysis review comments provided by the City indicate that CDOT must review the interchange configurations at Manila and I-70. The City states that the current interchange at Manila and I-70 is not suitable for truck traffic and that the interchange improvements will likely be required with any development. We need to collectively solve interim condition approaches that make development in the area feasible. There is also a City comment that the design must be consistent with SHAC. The approval of design for the Manila interchange and its supporting infrastructure should rely solely on TransPort Colorado. RMRP should be a party to the solution and timing for the interchange improvements, as they will be allocating trips to the interchange. The City has made comment regarding how to determine the suitability of the proposed interim condition to include roundabouts at the northern and southern onramps at Manila and I-70. The methodology required by the City will have potentially significant early impacts on costs, and how the RMRP Project will participate in those costs is of significance.

- The City has required four lanes of Manila Road must be constructed at a trigger point in the development of the our 1,154-acre rail-served industrial park development. Considering the likely timing of buildout between the RMRP Project and our rail-served industrial park, it is logical that coordination of the level of cost participation should be determined prior to approval of the RMRP development.

- The City is also requiring a grade separation at Schumaker Road and the UPRR. The RMRP Project will have significant future trips contributing to that infrastructure and RMRP should participate in the associated design and construction costs of that future grade separation.

Once again, TransPort Colorado requests a continuance of the RMRP Project until such time that critical coordination can occur between the municipal, county and developer levels to coordinate a viable infrastructure plan to these vital concerns.

Sincerely,

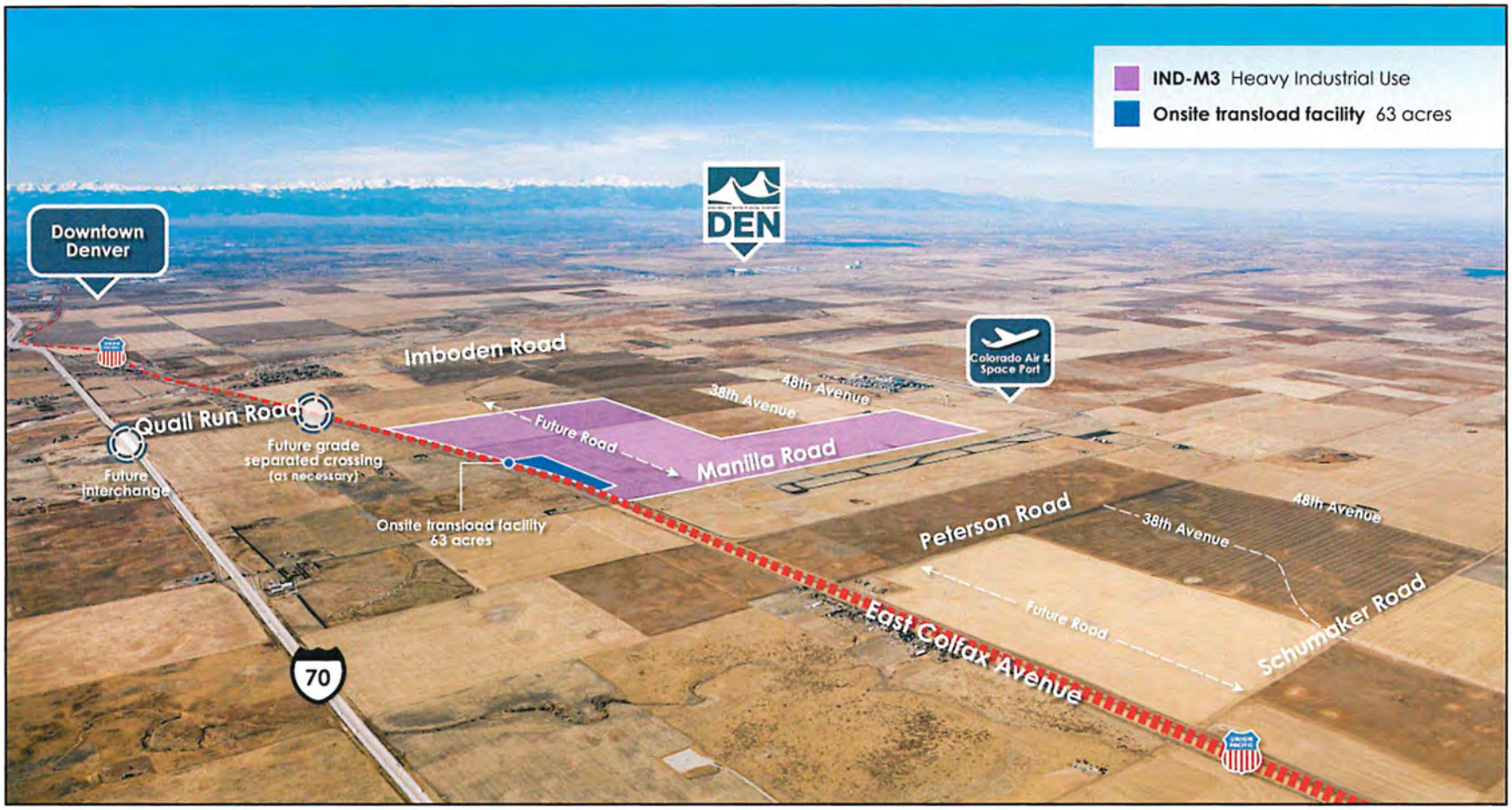
KBH

Kelsey B. Hall

Two Attachments Enclosed
Cc: TransPort Colorado – Steven Marshall, President & CEO

Attachment #1

TransPort Colorado: 1,154-acre Rail-Served Industrial Park



Attachment #2

TransPort Colorado: 1,154-acre Rail-Served Industrial Park

STATE OF COLORADO

Traffic & Safety
Region 1
2829 W. Howard Place
Denver, Colorado 80204

COLORADO
Department of Transportation

Project Name: **Rocky Mountain Rail Park**

		Highway:	Mile Marker:
Print Date:	11/14/2019	036	84.465

Environmental Comments:

Environmental will need to see environmental tech memos for the area of CDOT ROW that will become an access point(s), will have work or staging.

Traffic Comments:

I have no comments on the TIS.

Ronnie

From the Drawings it looks like the south location has two access. With Streets F & H accessing Colfax. Are these both full Access? This was not shown in the TIS. Only one access was evaluated in the TIS.

Jason Igo 11/12/2019

Maintenance Comments:

Resident Engineer Comments:

The residency will need to review the plans for any modifications made to SH36. The TIS lists several modifications that will need to be made to the state highway, and CDOT will need to review these plans to ensure they were designed to our standards and specifications. --kdd 11/13

No comments on Revision #3. --kdd 12/14/18

Permits Comments:

~~I have a number of issues and questions, too long to place in this form box. Please see attached memo dated 11-02-18. Seeking the favor of a reply letter with the next submittal outlining if-how CDOT issues have been addressed - RS 11-02-18~~

No further comments. Consultant has acknowledged concerns previsously raised. They are aware that permits will be per code (spacing & des ign) along SH 36 and what the TIS to accompany them will need to address. RS 12-17-18

On sheet 8 of 12, show x-section for SH 36. Property is responsible for public improvements deemed warranted abutting this RoW.

FDP Sheet 7 of 12 The notation *"proposed water line typ"* is inappropriately shown in center of SH 36. CDOT will not allow this, it must be moved-repositioned outside of ultimate roadway pavement design. No manholes in the pavement!

Sheet 7 of 12 Streets F & H do not appear to match Access code relative to position & spacing requirements. This concern was raised before under our previous review (Nov 2018). Access permits will be required for both. Plans

are not scalable, nor are the proposed roadway spacing dimensions offered. Design & safety considerations must be evaluated before we acknowledge acceptance of these locations.

Sheet 8 of 12 Add a cross section for SH 36. This highway flanks this property and RMRP is responsible for public improvements which are warranted. We wish to see that the full-build out profile fits in the RoW, along with utilities and roadside drainage. We are looking for a minimum of 140-ft ROW per the Adams County Transportation plan.

Existing Conditions map sheet 3 of 12. Lumping CDOT & UPRR ROW together is not appropriate. Please separate and illustrate the extent-width of the UPRR apart from CDOT ROW. We are not the same company, institution or ownership.

New access permit needed/required for both Manila & Petterson Rd intersections with SH 36. The TIS to accompany the permit application needs to ID DHV at all access locations. As we previously discussed, please include the I-70 ramps at Manila to ascertain if new permits may be warranted there by virtue of new traffic > 20% attributed to this development. Note: the responses to CDOT 's previous remarks states that no access to be considered from Manila, yet the plans appear to show via 30th Ave., a connection of/to Manila on the north side.

RS 11-06-19

Other Comments:

State Highway Access Permits are required for the three accesses to State Highway 36. One will be needed for Petterson Rd. on the north side. The Permittee for this permit should be Adams County since this is a County Road connection to the Highway. For the development south of Highway 36, two State Highway access permits are required. The west, full-movement access should be on the property line. A provision of the permit will be that the full-movement acccess would become a shared access with the adjacent property to the west at the time it develops. The east access will be limited to Right-in, Right-out only. And the spacing of the accesses must accommodate any required auxiliary lanes. No design waivers will be given for substandard required lanes. Point of contact for the access permits is Steve Loeffler who can be reached at 303-757-9891 or steven.loeffler@state.co.us

We need to review a drainage study for both the north and south developments to confirm that there will be no negative impact ot State Highway 36.

Any signing on these developments that will be visible to the State Highway msut be on-premise and cannot be either wholly or partly in the State Highway Right-of-Way. All signing must comply with any other applicable rules governing outdoor advertising in Colorado per **2 CCR 601-3**
---Steve Loeffler 11-14-19

Land Development APEN
Form APCD-223

Air Pollutant Emission Notice (APEN) and Application for Construction Permit

All sections of this APEN and application must be completed for both new and existing developments, including APEN updates. Incomplete APENs will be rejected and will require re-submittal. *Your APEN will be rejected if it is filled out incorrectly, is missing information, or lacks payment for the filing fee. The re-submittal will require payment for a new filing fee.*

This APEN is to be used for land development activities only. If your activity does not fall into this category, there may be a more specific APEN for your source. In particular, if your activity features excavation of commercially-sold material, you must use the Mining Operations APEN (Form APCD-222). If a specialty APEN is not available or does not satisfy your reporting needs, the General APEN (Form APCD-200) is available. A list of all available APEN forms can be found on the Air Pollution Control Division (APCD) website at: www.colorado.gov/cdphe/apcd.

This emission notice is valid for five (5) years. Submission of a revised APEN is required 30 days prior to expiration of the five-year term, or when a reportable change is made (significant emissions increase, increase production, new equipment, change in fuel type, etc.). See Regulation No. 3, Part A, II.C. for revised APEN requirements.

Permit Number: _____ AIRS ID Number: ___ / ___ / _____

[Leave blank unless APCD has already assigned a permit # and AIRS ID]

Section 1 – Administrative Information

Company Name[1]: _____ Contact Person: _____

Mailing Address: *(Include Zip Code)* _____ Phone Number: _____

_____ E-Mail Address[2]: _____

[1] Use the full, legal company name registered with the Colorado Secretary of State. This is the company name that will appear on all documents issued by the APCD. Any changes will require additional paperwork.

[2] Permits, exemption letters, and any processing invoices will be issued by the APCD via e-mail to the address provided.

Section 2 – Requested Action

☐ NEW land development construction permit (and check one below)

☐ Request coverage under construction permit ☐ Request coverage under General Permit GP03

If General Permit coverage is requested, only pages 1-2 are required, and the General Permit registration fee of $62.50 must be submitted along with the APEN filing fee.

- OR -

☐ MODIFICATION to existing permit *(check each box below that applies)*

☐ Increase size of project ☐ Increase duration of project

- OR -

☐ APEN submittal for update only (Blank APENs will not be accepted)

Additional Info & Notes: _____

Permit Number: _____ AIRS ID Number: ____ / ____ / _____

[Leave blank unless APCD has already assigned a permit # and AIRS ID]

Section 3 – General Information

Project Name: _____

General description of land development project: _____

_____

Street Address (if applicable): _____

County: _____ Section: _____ Township: _____ Range: _____

Project Timeline

Date earthmoving will commence: _____ Date earthmoving will stop: _____

Estimated time to complete entire project (includes buildings): _____ months

Project Area

Total area of project subject to earthmoving: _____ acres

Maximum disturbed area at any one time: _____ acres

Paving

☐ Check box if no paving will be completed at this location.

Area to be paved: _____ acres Date paving to be completed: _____

List any known or suspected contaminants in the soil:

_____

NOTE: Contaminated soil will prevent your project from being covered by the General Permit GP03.

Brief description of how project development will occur:
(May consist of timeline, project phases, etc. Attach additional pages if necessary.)

_____

_____

IF YOU HAVE REQUESTED COVERAGE UNDER GENERAL PERMIT GP03, AN AUTHORIZED SIGNATURE IS REQUIRED IN SECTION 4. IF YOU HAVE REQUESTED COVERAGE UNDER A CONSTRUCTION PERMIT, AN AUTHORIZED SIGNATURE IS REQUIRED IN SECTION 6 (SEE PAGE 4).

Section 4 – Applicant Certification (GP03 Coverage Only)

I hereby certify that all information contained herein and information submitted with this application is complete, true, and correct. I further certify that this source is and will be operated in full compliance with each condition of General Permit GP03.

_____

Signature of Legally Authorized Person (not a vendor or consultant) Date

_____

Name (print) Title

Permit Number: _____ AIRS ID Number: ____ / ____ / _____

[Leave blank unless APCD has already assigned a permit # and AIRS ID]

Section 5 – Fugitive Dust Control Plan for Land Development

If coverage under a construction permit is requested, this plan must be submitted with the APEN. DO NOT complete the rest of this form if you have requested coverage under General Permit GP03.

Regulation No. 1 requires that a fugitive dust control plan be submitted by applicants whose source/activity results in fugitive dust emissions. The control plan must enable the source to minimize emissions of fugitive dust to a level that is technologically feasible and economically reasonable. If the control plan is not adequate for minimizing emissions, a revised control plan may be required. The control plan (if acceptable to the division) will be used for inspection and enforcement purposes on the sources.

Check the boxes for dust control measures which you propose for your activity. You are required to apply the control measures as listed in the control plan. You may be subject to penalties if you fail to apply the control measures as reported. Use separate sheets if more space is needed.

Section 5A - Control of Unpaved Roads On-Site

Watering: ☐ None ☐ As needed ☐ Frequent[3]: _____ times/day

Surface is graveled: ☐ No ☐ Yes

Chemical stabilizer applied: ☐ No ☐ Yes Type: _____
(e.g. mag chloride, resin, etc.)

Vehicle Speed Limits: ☐ No ☐ Yes Posted speed limit on haul road: _____ mph

[3] If "Frequent" is selected, your permit may include a requirement to water roads as often as listed in this APEN.

Section 5B - Control of Disturbed Surface Areas On-Site

☐ Watering *(choose one option from below)*
- ☐ Frequent (2 or more times per day)
- ☐ As needed

☐ Chemical stabilizer

☐ Vehicle speed limited to _____ mph maximum. Speed limit signs must be posted.

☐ Revegetation *(must occur within one year of site disturbance)*
- ☐ Seeding with mulch
- ☐ Seeding without mulch

☐ Furrows at right angle to prevailing wind

Depth of furrows _____ inches (must be greater than 6")

☐ Compaction of disturbed soil[4] *(choose one option from below)*
- ☐ Foundation areas only
- ☐ All disturbed soil

☐ Wind breaks

Type: _____ *(e.g. snow fence, silt fence, etc.)*

☐ Synthetic or natural cover for steep slopes

Type: _____ *(e.g. netting, mulching, etc.)*

☐ Other *(specify)* _____

[4] Compaction must occur on a daily basis, and it must be to within 90% of maximum compaction, as determined by a Proctor test.

Permit Number: _____ AIRS ID Number: ___ / ___ / _____

[Leave blank unless APCD has already assigned a permit # and AIRS ID]

Section 5C – Prevention of Fugitive Dust from Paved Surfaces

Gravel entryways: ☐ No ☐ Yes

Washing of vehicle wheels: ☐ No ☐ Yes

Section 5D – Cleanup of Fugitive Dust from Paved Surfaces

Frequency: _____ times per day

Street sweeping: ☐ No ☐ Yes

Hose with water: ☐ No ☐ Yes

List any additional source of emissions or control methods:

Section 6 – Applicant Certification (Construction Permit Coverage Only)

I hereby certify that all information contained herein and information submitted with this application is complete, true, and correct.

Signature of Legally Authorized Person (not a vendor or consultant) Date

Name (print) Title

Check the appropriate box to request a copy of the:

☐ Draft permit prior to issuance

(Checking this box may result in an increased fee and/or processing time)

This emission notice is valid for five (5) years. Submission of a revised APEN is required 30 days prior to expiration of the five-year term, or when a reportable change is made (significant emissions increase, increase production, new equipment, change in fuel type, etc.). See Regulation No. 3, Part A, II.C. for revised APEN requirements.

Send this form along with $191.13 and the General Permit registration fee of $62.50, if applicable, to:

Colorado Department of Public Health and Environment
Air Pollution Control Division
APCD-SS-B1
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Make check payable to:

Colorado Department of Public Health and Environment

For more information or assistance call:

Small Business Assistance Program
(303) 692-3175 or (303) 692-3148

APCD Main Phone Number
(303) 692-3150

Or visit the APCD website at:

https://www.colorado.gov/cdphe/apcd

Nick Eagleson

From: Joseph Boateng <JBoateng@arapahoegov.com>
Sent: Friday, November 15, 2019 9:56 AM
To: Nick Eagleson
Subject: ROCKY MOUNTAIN RAIL PARK

Dear Mr. Nick Eagleson

Arapahoe County Engineering thanks you for giving us the opportunity to review the
Rocky Mountain Rail Park. The Engineering Division has no comments regarding the referral at this time based on the information submitted.

Please know that other Divisions in the Public Works Department may submit comments as well.

If you have any questions, please feel free to contact our offices.

Sincerely,

Joseph Boateng
Engineering Services

Joseph Boateng, P.E.
Engineering I
Arapahoe County Public Works & Development
6924 S Lima St, Centennial, CO 80112-3853
Direct: 303-910-9268 | Main: 720-874-6575
jboateng@arapahoegov.com **http://www.arapahoegov.com**

Nick Eagleson

From: Rodriguez, Stephen E <srodrigu@auroragov.org>
Sent: Thursday, November 14, 2019 4:56 PM
To: Nick Eagleson
Subject: Rocky Mountain Rail Park Comments

Hello Nick:

The following is our comments on the proposed Final Development Plan to establish Rocky Mountain Rail Park PUD.

The City of Aurora respectfully requests that coordination occur between the Aurora, Adams County, Rocky Mountain Rail Park, Urban Drainage and Flood Control District (UDFCD) and TransPort, to discuss infrastructure needs relating to traffic, drainage, water and sewer as well as any other infrastructure. Coordination should occur prior to the approval by Adams County of the Rocky Mountain Rail Park Final Development Plan. Thank you for the opportunity to comment on this proposal.

Stephen Rodriguez

Supervisor
City of Aurora Planning and Development Services
303.739.7186

Nick Eagleson

From: Keith & Kate Sauder <kksauder@gmail.com>
Sent: Sunday, October 27, 2019 2:56 PM
To: Nick Eagleson
Subject: RMRP final development plan

Please be cautious: This email was sent from outside Adams County

Dear Mr. Eagleson,
Thank you for sending information about RMRP's final play and final development plan. Is there an updated traffic study, or final plans for road improvements for the Colfax/Petterson intersection? Page 12 of the development plan indicates that the road will be widened, but it is a bit difficult to interpret. Please send further details, if available.
Thank you,
Kate Sauder
720-717-1216

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Request for Comments

Case Name: ROCKY MOUNTAIN RAIL PARK

Project Number: PRC2019-00012

October 24, 2019

The Adams County Board of County Commissioners are requesting comments on the following applications: **1)Final Plat to create 11 lots and 11 tracts; 2)Final Development Plan to establish the Rocky Mountain Rail Park Planned Unit Development on 620 acres.** This request is located at NW corner of Petterson and Colfax. The Assessor's Parcel Numbers are: 0181700000108, 0181700000289, 0181700000290.

Applicant Information: RAIL LAND COMPANY LLC
GREG DANGLER
4601 DTC BLVD STE 130
DENVER, CO 80237

Please forward any written comments on this application to the Community and Economic Development Department at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216 or call (720) 523-6800 by 11/14/2019 in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to NEagleson@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional colored maps can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

N. Eagleson

Nick Eagleson
Planner III

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Public Hearing Notification

Case Name:	Rocky Mountain Rail Park
Case Number:	PRC2019-00012
Board of County Commissioners Hearing Date:	Tuesday, September 1, 2020 at 9:30 a.m.

July 21, 2020

A public hearing has been set by the Adams County Board of County Commissioners to consider the following request: A REQUEST FOR 1) A FINAL DEVELOPMENT PLAN TO ESTABLISH THE ROCKY MOUNTIAN RAIL PARK PLANNED UNIT DEVELOPMENT ON 620 ACRES; 2) A FINAL PLAT TO CREATE 11 LOTS, AND 3) A WAIVER FROM THE SUBDIVISION DESIGN STANDARDS

The Assessor's Parcel Number(s) 0181700000289, 0181700000290, 0181700000108
Location: Northwest corner of the intersection of Colfax Avenue and Petterson Road

Applicant Information: Rocky Mountain Industrials

The Board of County Commissioners meeting is broadcast live on the Adams County YouTube channel and members of the public will be able to submit comments prior to the start of the public hearing that will then be entered into the record. The eComment period opens when the agenda is published and closes at 4:30 p.m. the Monday prior to the noticed meeting. For instructions on how to access the public hearing and submit comments, please visit http://www.adcogov.org/bocc for up to date information.

This will be a public hearing and any interested parties may attend and be heard. The Applicant and Representative's presence at these hearings is requested. The full text of the proposed request and additional colored maps can be obtained by accessing the Adams County Community and Economic Development Department website at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Nick Eagleson
Case Manager / Senior Strategic Planner
neagleson@adcogov.org 720-523-6878

PUBLICATION REQUEST

Case Name: Rocky Mountain Rail Park
Case Number: PRC2019-00012
Board of County Commissioners Hearing Date: September 1st, 2020 at 9:30 a.m.
Case Manager: Nick Eagleson neagleson@adcogov.org 720-523-6878
Request: Waiver of Subdivision Design Standards, Final Plat to create 11 lots and Final Development Plan to establish Rocky Mountain Rail Park Planned Unit Development on 620 acres
Parcel Number: 0181700000289, 0181700000290, 0181700000108
Applicant: Rocky Mountain Industrials 4601 DTC Blvd, Suite 130 Denver, CO 80237
Owner: Rocky Mountain Industrials 4601 DTC Blvd, Suite 130 Denver, CO 80237
Legal Description: SECT,TWN,RNG:26-3-64 DESC: PARC OF LAND IN E2 SECS 23 AND 26 DESC AS FOLS BEG AT NE COR SD SEC 23 TH S 5292/16 FT TO NE COR SD SEC 26 TH S 3841/38 FT TO A PT ON N ROW LN OF UP RR TH S 87D 57M W 2262/36 FT TH N 3932/35 FT TO S LN OF SD SEC 23 TH CONT N 5296/70 FT TH E 2259/45 FT TO POB EXC E 30 FT FOR RD 467/179A.

SECT,TWN,RNG:26-3-64 DESC: PARC OF LAND IN S2 SE4 SEC 26 DESC AS FOLS BEG AT SW COR SD SE4 SD PT BEING THE TRUE POB TH N 00D 54M 51S W 849/45 FT TO A PT ON S ROW LN OF US HIWAY NO 36 TH N 87D 57M 03S E 2449/30 FT TH S 01D 04M 25S E 949/09 FT TH N 89D 43M 11S W 2452 FT TO POB 50/582A

SECT,TWN,RNG:35-3-64 DESC: N2 NE4 AND N2 N2 S2 NE4 100A

Virtual Meeting and Public Comment Information:
This meeting will be held virtually. Please visit http://www.adcogov.org/bocc for up to date information on accessing the public hearing and submitting comment prior to the hearing. The full text of the proposed request and additional colored maps can be obtained by accessing the Adams County Community and Economic Development Department website at www.adcogov.org/planning/currentcases.

Referral Listing
Case Number PRC2019-00012
ROCKY MOUNTAIN RAIL PARK FINAL DEVELOPMENT PLAN

Agency	Contact Information
Adams County Attorney's Office	Christine Fitch CFitch@adcogov.org 4430 S Adams County Pkwy Brighton CO 80601 720-523-6352
Adams County CEDD Addressing	Marissa Hillje PLN 720.523.6837 mhillje@adcogov.org
Adams County CEDD Development Services Engineer	Devt. Services Engineering 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6800
Adams County CEDD Right-of-Way	Marissa Hillje 4430 S. Adams County Pkwy. Brighton CO 80601 720-523-6837 mhillje@adcogov.org
Adams County Construction Inspection	Gordon .Stevens 4430 S. Adams County Pkwy Brighton CO 80601 720-523-6965 gstevens@adcogov.org
Adams County Development Services - Building	Justin Blair 4430 S Adams County Pkwy Brighton CO 80601 720-523-6825 JBlair@adcogov.org
Adams County Parks and Open Space Department	Aaron Clark mpedrucci@adcogov.org (303) 637-8005 aclark@adcogov.org
Adams County Sheriff's Office: SO-HQ	Rick Reigenborn (303) 654-1850 rreigenborn@adcogov.org
Adams County Sheriff's Office: SO-SUB	SCOTT MILLER 720-322-1115 smiller@adcogov.org

Agency	Contact Information
Adams County Treasurer	Lisa Culpepper 4430 S Adams County Pkwy Brighton CO 80601 720.523.6166 lculpepper@adcogov.org
BENNETT FIRE DISTRICT #7	Captain Caleb J Connor 825 SHARIS CT BENNETT CO 80102 303-532-7733 303-644-3572 CalebConnor@BennettFireRescue.org
BENNETT FIRE DISTRICT #7	CHIEF EARL CUMELY 825 SHARIS CT BENNETT CO 80102 303-644-3434 ecumley941@aol.com
BENNETT PARK AND RECREATION	Chris Raines PO BOX 379 455 S. 1ST ST. BENNETT CO 80102-0379 303-644-5041 Director@bennettrec.org
BENNETT SCHOOL DISTRICT 29J	Robin Purdy 615 7TH ST. BENNETT CO 80102 303-644-3234 Ext: 8203 robinp@bsd29j.com
Century Link, Inc	Brandyn Wiedreich 5325 Zuni St, Rm 728 Denver CO 80221 720-578-3724 720-245-0029 brandyn.wiedrich@centurylink.com
CITY OF AURORA - WATER AND SAN. DEPT.	PETER BINNEY 15151 E ALAMEDA PKWY #3600 AURORA CO 80012 303-739-7370 pbinney@ci.aurora.co.us
CITY OF AURORA ATTN: PLANNING DEPARTMENT	Porter Ingrum 15151 E ALAMEDA PKWY 2ND FLOOR AURORA CO 80012 (303) 739-7227 303.739.7000 pingrum@auroragov.org
Code Compliance Supervisor	Eric Guenther eguenther@adcogov.org 720-523-6856 eguenther@adcogov.org
COLO DIV OF MINING RECLAMATION AND SAFETY	ANTHONY J. WALDRON - SENIOR ENV DEPT. OF NATURAL RESOURCES 1313 SHERMAN ST, #215 DENVER CO 80203 303-866-4926 tony.waldron@state.co.us

Agency	Contact Information
COLO DIV OF WATER RESOURCES	Joanna Williams OFFICE OF STATE ENGINEER 1313 SHERMAN ST., ROOM 818 DENVER CO 80203 303-866-3581 joanna.williams@state.co.us
COLO DIV OF WATER RESOURCES	Joanna Williams OFFICE OF STATE ENGINEER 1313 SHERMAN ST., ROOM 818 DENVER CO 80203 303-866-3581 joanna.williams@state.co.us
Colorado Air and Spaceport	Dave Ruppel 5200 Front Range Airport WATKINS CO 80137-7131 303-261-9100 druppel@ftg-airport.com
COLORADO DIVISION OF WILDLIFE	Eliza Hunholz Northeast Regional Engineer 6060 BROADWAY DENVER CO 80216-1000 303-291-7454 eliza.hunholz@state.co.us
COLORADO DIVISION OF WILDLIFE	Serena Rocksund 6060 BROADWAY DENVER CO 80216 3039471798 serena.rocksund@state.co.us
COLORADO GEOLOGICAL SURVEY	Jill Carlson 1500 Illinois Street Golden CO 80401 303-384-2643 303-384-2655 CGS_LUR@mines.edu
Colorado Geological Survey: CGS_LUR@mines.edu	Jill Carlson Mail CHECK to Jill Carlson 303-384-2643 303-384-2655 CGS_LUR@mines.edu
COMCAST	JOE LOWE 8490 N UMITILLA ST FEDERAL HEIGHTS CO 80260 303-603-5039 thomas_lowe@cable.comcast.com
Denver International Airport	Tim Hester Planning & Design 8500 Peña Boulevard Denver CO 80249 (303) 342-2391 Tim.Hester@flydenver.com

Agency	Contact Information
FEDERAL AVIATION ADMINISTRATION	LINDA BRUCE 26805 E 68TH AVENUE, #224 DENVER CO 80249-6361 303-342-1264 linda.bruce@faa.gov
IREA	Brooks Kaufman PO Box Drawer A 5496 North US Hwy 85 Sedalia CO 80135 303-688-3100 x105 bkaufman@intermountain-rea.com
METRO WASTEWATER RECLAMATION	CRAIG SIMMONDS 6450 YORK ST. DENVER CO 80229 303-286-3338 CSIMMONDS@MWRD.DST.CO.US
NS - Code Compliance	Gail Moon gmoon@adcogov.org 720.523.6833 gmoon@adcogov.org
Rocky Mountain Rail Park Metropolitan District	Greg Dangler Rail Land Company LLC 4601 DTC Blvd Ste 120 Denver CO 80237 7204598675 GDANGLER@RMRHOLDINGS.COM
TRI-COUNTY HEALTH DEPARTMENT	MONTE DEATRICH 4201 E. 72ND AVENUE SUITE D COMMERCE CITY CO 80022 (303) 288-6816 mdeatrich@tchd.org
TRI-COUNTY HEALTH DEPARTMENT	Sheila Lynch 6162 S WILLOW DR, SUITE 100 GREENWOOD VILLAGE CO 80111 720-200-1571 landuse@tchd.org
Tri-County Health: Mail CHECK to Sheila Lynch	Tri-County Health landuse@tchd.org .
UNION PACIFIC RAILROAD	Schia Cloutier 1400 DOUGLAS ST STOP 1690 OMAHA NE 68179 402-544-8552 smcloutier@up.com
UNITED STATES POST OFFICE	MARY C. DOBYNS 56691 E COLFAX AVENUE STRASBURG CO 80136-8115 303-622-9867 mary.c.dobyns@usps.gov

Agency	Contact Information
US EPA	Stan Christensen 1595 Wynkoop Street DENVER CO 80202 1-800-227-8917 christensen.stanley@epa.gov
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com

ADAMS COUNTY
4430 S ADAMS COUNTY PKWY 5TH FLOOR
BRIGHTON CO 80601-8222

CRISMAN E KENT
41775 E 48TH AVE
BENNETT CO 80102

DANHAUER PATRICIA ELAINE FAMILY TRUST
2812 COUNTRYSIDE TRL
KELLER TX 76248-8308

FRONT RANGE 1-70 CAPITAL ASSETS LLC
C/O JEFFREY SMITH
500 106TH AVE NE UNIT 3815
BELLEVUE WA 98004-8694

HAUET WILLIAM A AND
HAUET VALERIE A
41420 HIWAY 36
BENNETT CO 80102

KLAUSNER ERMA M
41070 US HWY 36
BENNETT CO 80102

LAZY K BAR C LLC
41775 E 48TH AVE
BENNETT CO 80102-9100

MARKS JAMES
5790 TRUCKEE ST
CENTENNIAL CO 80015-3094

MORELOCK KENNETH M AND
MORELOCK E RAYNETTE
41140 HIWAY 36
BENNETT CO 80102

PINEDO MARCELINO AND
PINEDO BELINDA
41220 E HIGHWAY 36
BENNETT CO 80102

RAIL LAND COMPANY LLC
4601 DTC BLVD STE 120
DENVER CO 80237-2575

REMINGTON S A
40940 HIWAY 36
BENNETT CO 80102

REVOCABLE TRUST OF CARROLL J LISCO THE
430 TANK FARM ROAD
DOUGLAS WY 82633

STOKER KENT E AND
STOKER BRENT A
41340 E HIWAY 36
BENNETT CO 80102

TEAGUE ELSBETH L TRUST
14050 E LINEVALE PL NO. 404
AURORA CO 80014

THE LEWIS FAMILY TRUST
24313 N FM 219
STEPHENVILLE TX 76401-9161

VANDOORN DAVID D AND
VANDOORN SANDRA
41540 US HWY 36
BENNETT CO 80102-7858

WALTERS ANTHONY L AND
WATLERS KELLY P
41280 E HIWAY 36
BENNETT CO 80102

WESTERN TRANSPORT LLC
1331 17TH ST STE 1000
DENVER CO 80202-1566

CARDIN JOHN C AND CARDIN DONNA F
OR CURRENT RESIDENT
41460 US HIGHWAY 36
BENNETT CO 80102-7857

MAXWELL SHANNON K AND
MAXWELL GREGG A
OR CURRENT RESIDENT
41660 US HIGHWAY 36
BENNETT CO 80102-7859

SAUDER KEITH RANDALL AND
SAUDER KATHERINE ANN
OR CURRENT RESIDENT
2625 N PETERSON RD
BENNETT CO 80102-8813

SWENSON JERRY A
OR CURRENT RESIDENT
41020 US HIGHWAY 36
BENNETT CO 80102-8626

ZUHLKE RONALD L JR AND
ZUHLKE HEIDI
OR CURRENT RESIDENT
41620 US HIGHWAY 36
BENNETT CO 80102-7859

CURRENT RESIDENT
41140 US HIGHWAY 36
BENNETT CO 80102-7800

CURRENT RESIDENT
41220 US HIGHWAY 36
BENNETT CO 80102-7800

CURRENT RESIDENT
41280 US HIGHWAY 36
BENNETT CO 80102-7800

CURRENT RESIDENT
41340 US HIGHWAY 36
BENNETT CO 80102-7857

CURRENT RESIDENT
41420 US HIGHWAY 36
BENNETT CO 80102-7857

CURRENT RESIDENT
41540 US HIGHWAY 36
BENNETT CO 80102-7858

CURRENT RESIDENT
40940 US HIGHWAY 36
BENNETT CO 80102-8626

CURRENT RESIDENT
41070 US HIGHWAY 36
BENNETT CO 80102-8626

CURRENT RESIDENT
1614 N MANILA RD
BENNETT CO 80102-8868

CURRENT RESIDENT
1616 MANILLA RD
BENNETT CO 80102-8868

CURRENT RESIDENT
1616 N MANILA RD
BENNETT CO 80102-8868


DEVELOPMENT PROPOSAL
PD
PLANNED UNIT DEVELOPMENT
720.523.6800
DEVELOPMENT PROPOSAL
P
SUBDIVISION PLAT

Rocky Mountain Rail Park

PRC2019-00012

NW Corner of U.S. Highway 36 & Petterson Road

September 1, 2020

Board of County Commissioners Public Hearing

Community and Economic Development Department

Case Manager: Nick Eagleson

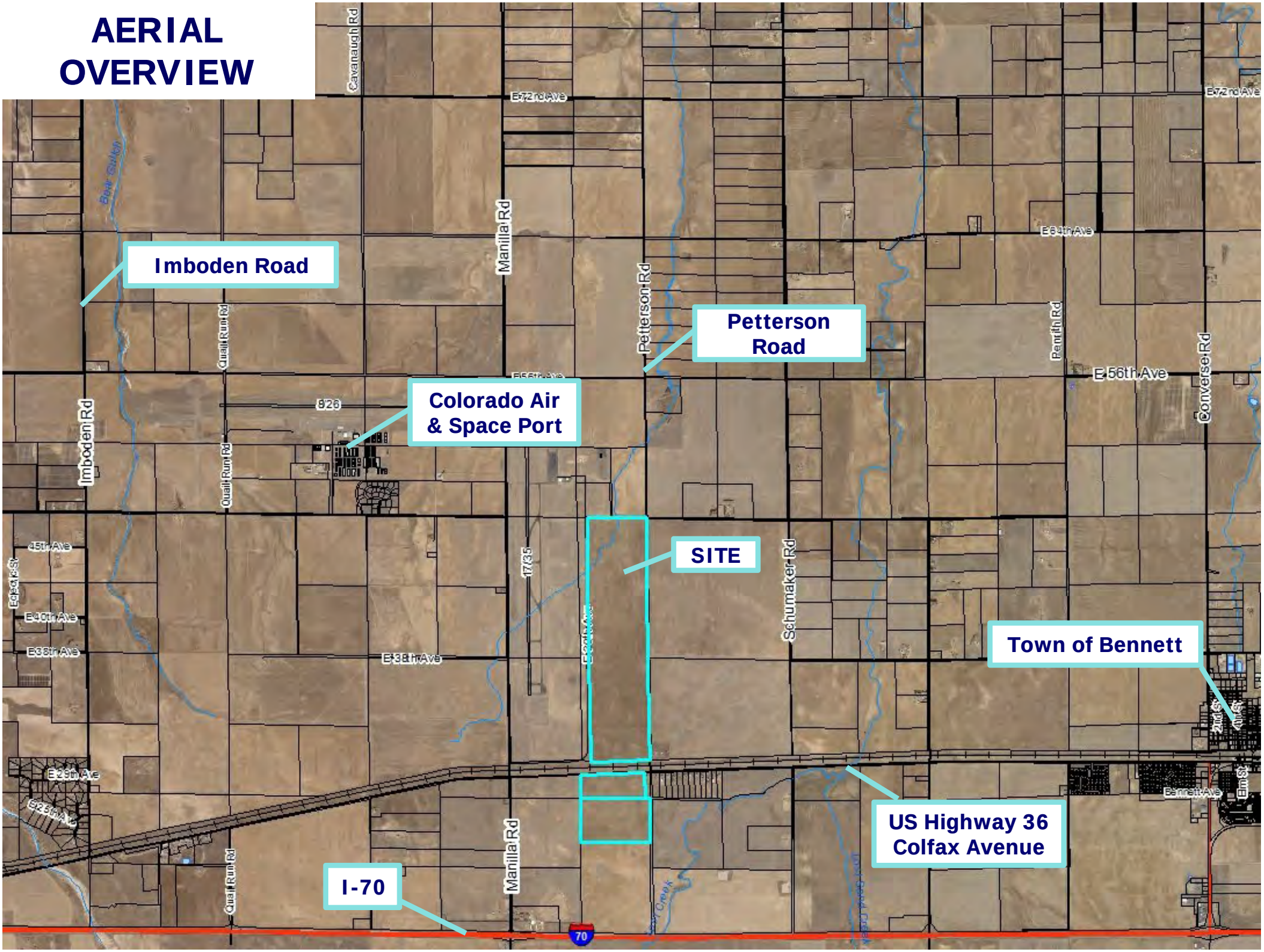
Requests

1. Final Plat
   - Create 11 lots and 11 tracts
2. Final Development Plan
   - Establish the Rocky Mountain Rail Park Planned Unit Development
3. Master Development Agreement
4. Waiver from Subdivision Design Standards

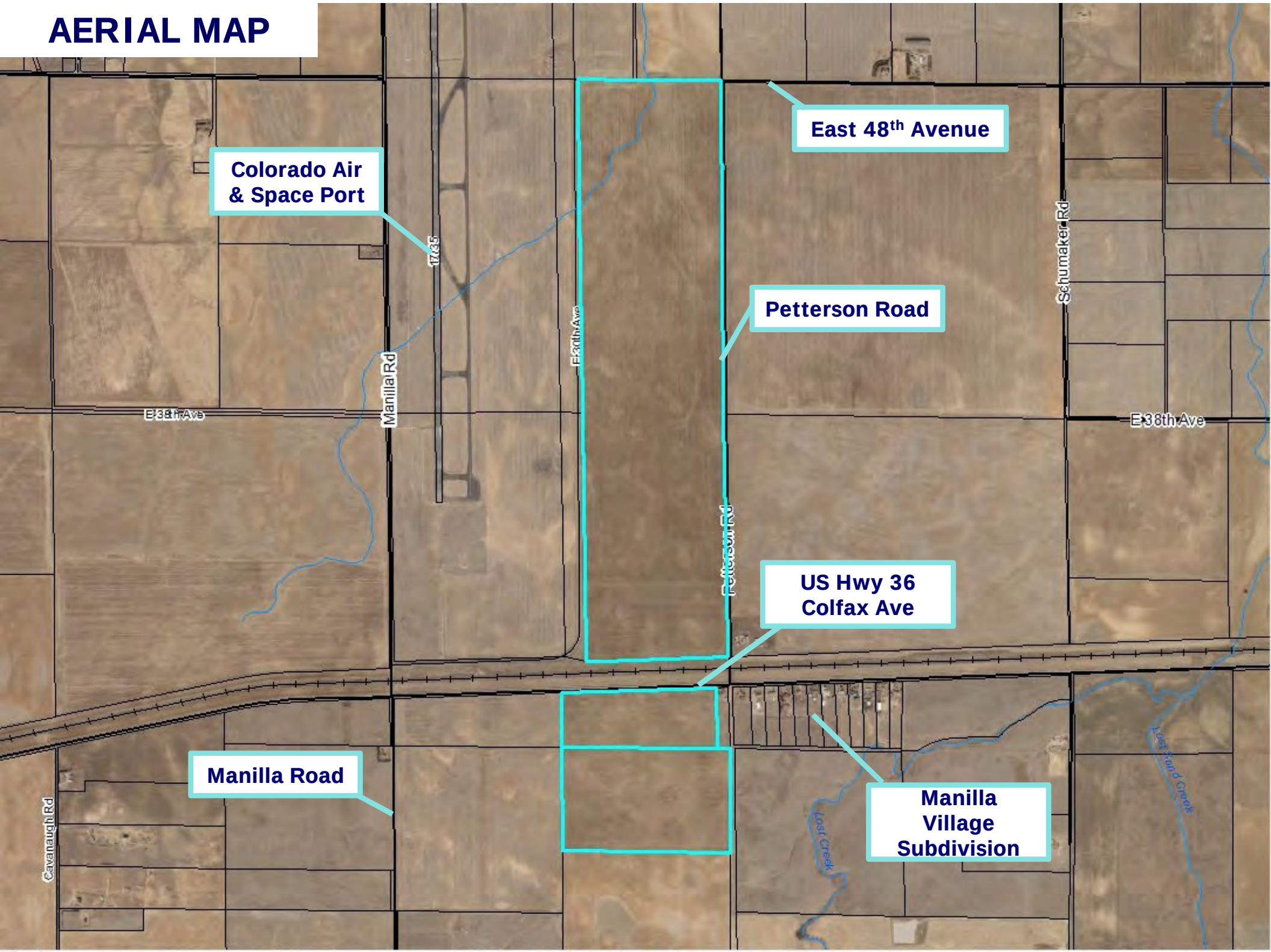
Background

- Proposal for industrial business park utilizing railroad infrastructure
- Uses will range from commercial to light and heavy industrial
- Approximately 620 acres
- May also serve supporting businesses for Colorado Air and Space Port

AERIAL OVERVIEW

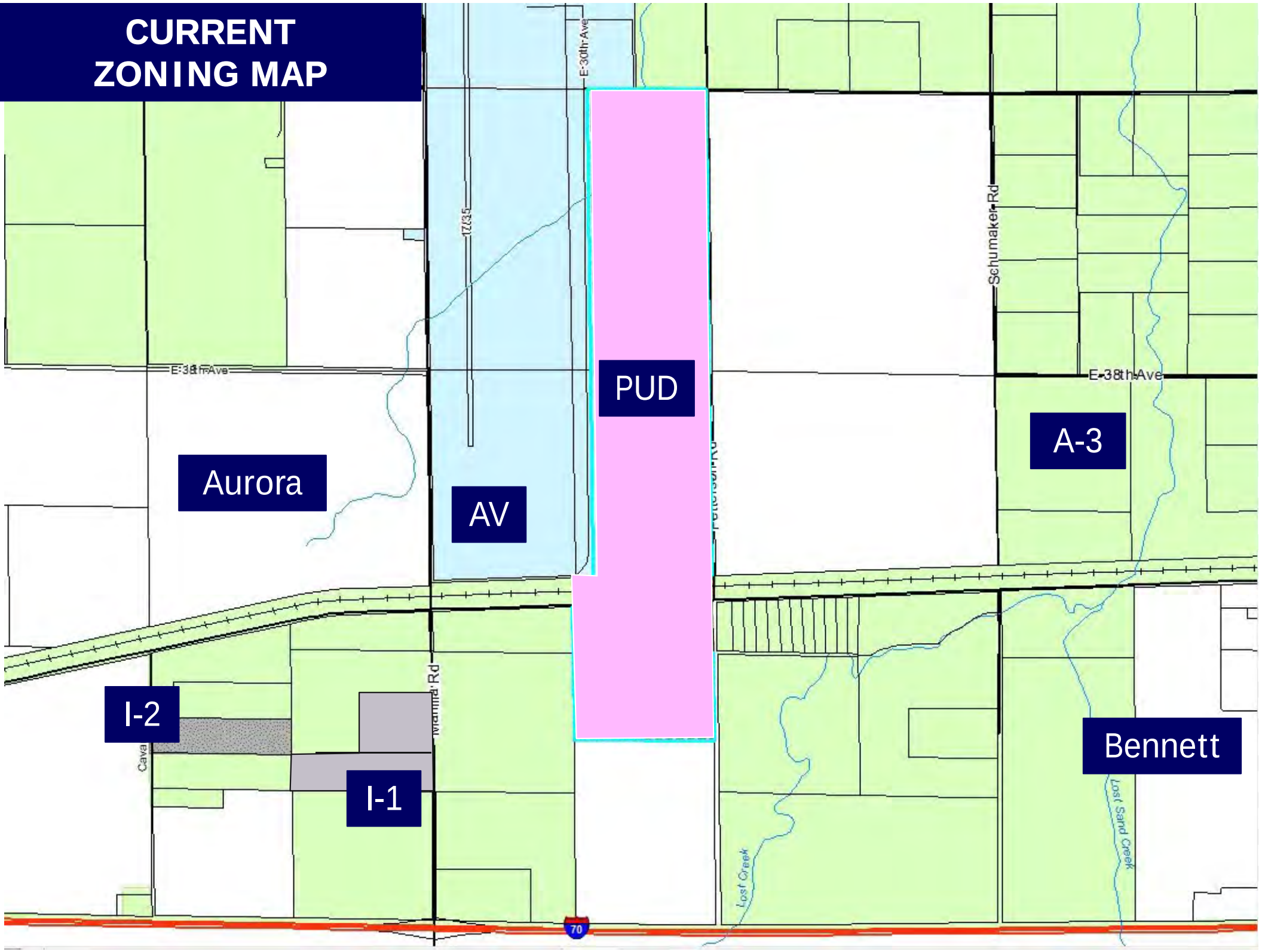


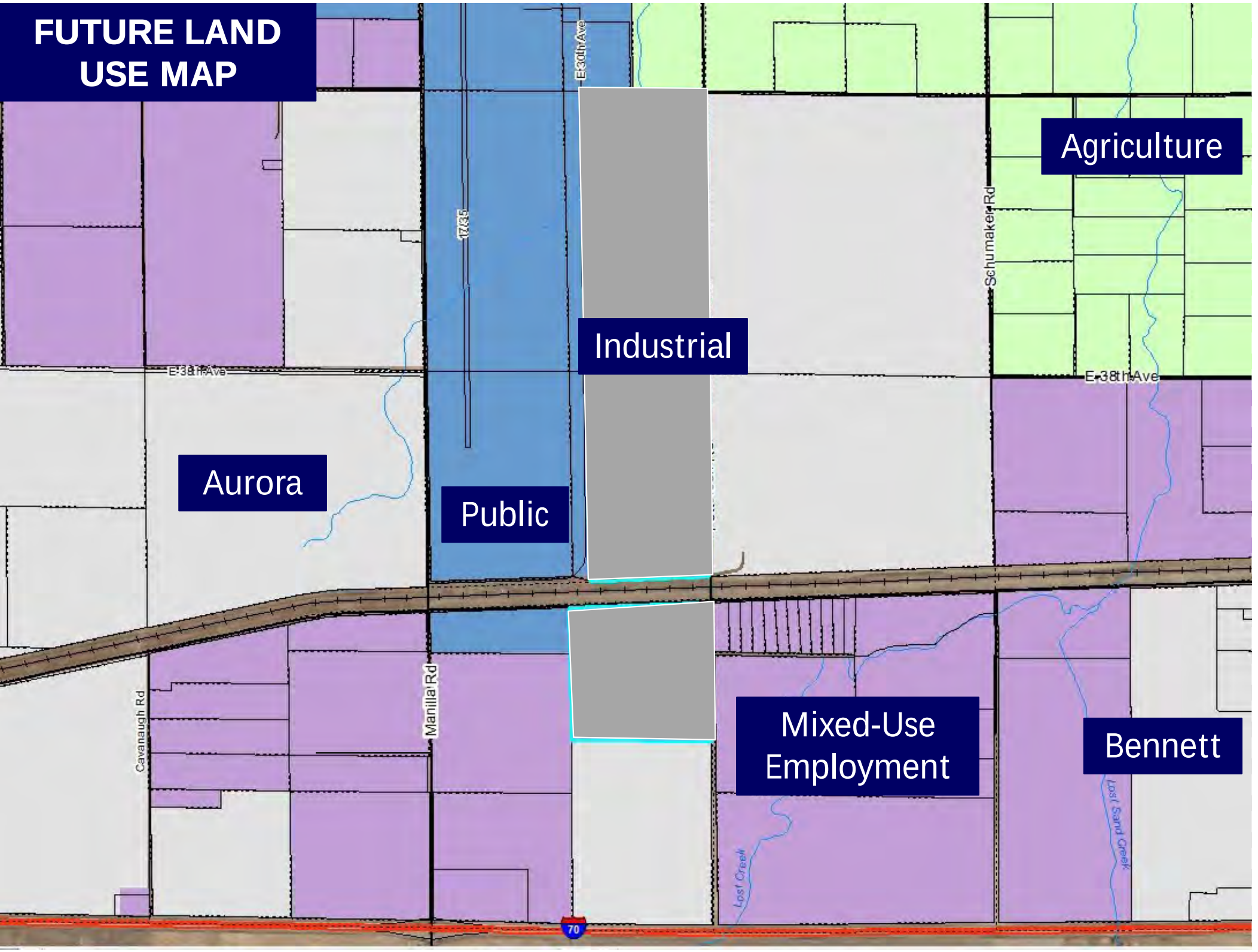
AERIAL MAP


East 48th Avenue
Colorado Air & Space Port
Petterson Road
US Hwy 36 Colfax Ave
Manilla Road
Manilla Village Subdivision
Manilla Rd
E 38th Ave
Schumaker Rd
Cavanaugh Rd
Lost Creek

Background

- Previous Requests and Approvals:
  - Comprehensive Plan Amendment to change the future land use designation from Mixed-Use Employment to Industrial.
  - Zoning map amendment to change the zoning designation of the property to Planned Unit Development (PUD).
  - Preliminary Plat
  - Preliminary Development Plan
  - Board of County Commissioners approved all four requests on June 18, 2019.


CURRENT ZONING MAP
E 30th Ave
I-25
Schumaker Rd
E 38th Ave
PUD
A-3
Aurora
AV
Imboden Rd
I-2
I-1
Bennett
Lost Creek
Lost Sand Creek
70


FUTURE LAND USE MAP
Agriculture
Industrial
Aurora
Public
Mixed-Use Employment
Bennett
E 38th Ave
E 38th Ave
E 30th Ave
I 25
Schumaker Rd
Manilla Rd
Cavanaugh Rd
Lost Creek
Lost Sand Creek
70

Criteria for Approval (Final Plat)

Section 2-02-19-04-05

- Consistent with Approved Preliminary Plat
- Conformance with Subdivision Standards
- Adequate Water Supply
- Adequate Sewage Disposal System
- Identify Geologic and Topographic Concerns
- Adequate Drainage
- Incorporating Infrastructure

Criteria for Approval (Final Development Plan)

Section 2-02-10-04-05

- Conformance to Comprehensive Plan
- Conforms to PUD Standards
- Consistent with Approved PDP
- Construction Plans Meet Standards

Master Agreement

- Framework for Development of the Site
  - Addresses the manner and timing of the completion of improvements.
  - Responsibility for payment of the costs of improvements associated with the development.
- Subsequent SIA's will be provided for future lots within the development, which will come before BOCC for approval.
- If any triggered improvements are to be dedicated to another jurisdiction, then the County shall not issue a lot development permit until after Developer has submitted materials to regulating jurisdiction.

Master Agreement

- County shall not issue a Certificate of Occupancy for the development until the regulatory jurisdiction has accepted the triggered improvements.
- County Staff has reviewed the MA and confirmed the proposed agreements are in compliance with the Development Standards and Regulations.

Criteria for Approval
(Waiver from Subdivision Design Standards)
Section 2-02-17-05

- Extraordinary hardships or practical difficulties result from the strict compliance with these standards and regulations.
- The purpose of these standards and regulations are served to a greater extent by the alternative proposal.
- The waiver does not have the effect of nullifying the purpose of these standards and regulations.

Staff Analysis

- Changes to Final Plat from the approved Preliminary Plat
  - Additional access from Petterson Rd. to internal drive
  - Minor changes to lot dimensions
  - Changes to size and location of Tracts

- Development Plan Changes
  - Use chart previously had some uses listed as Special Review (SR). That has now been changed to Conditional (C) and will need to go through the Conditional Use Permit process
    - Hazardous Waste Treatment Facility
    - Paint and Enamel Manufacturing
    - Fossil Fuel Manufacturing
  - Soft surface trail along western edge of property has been removed

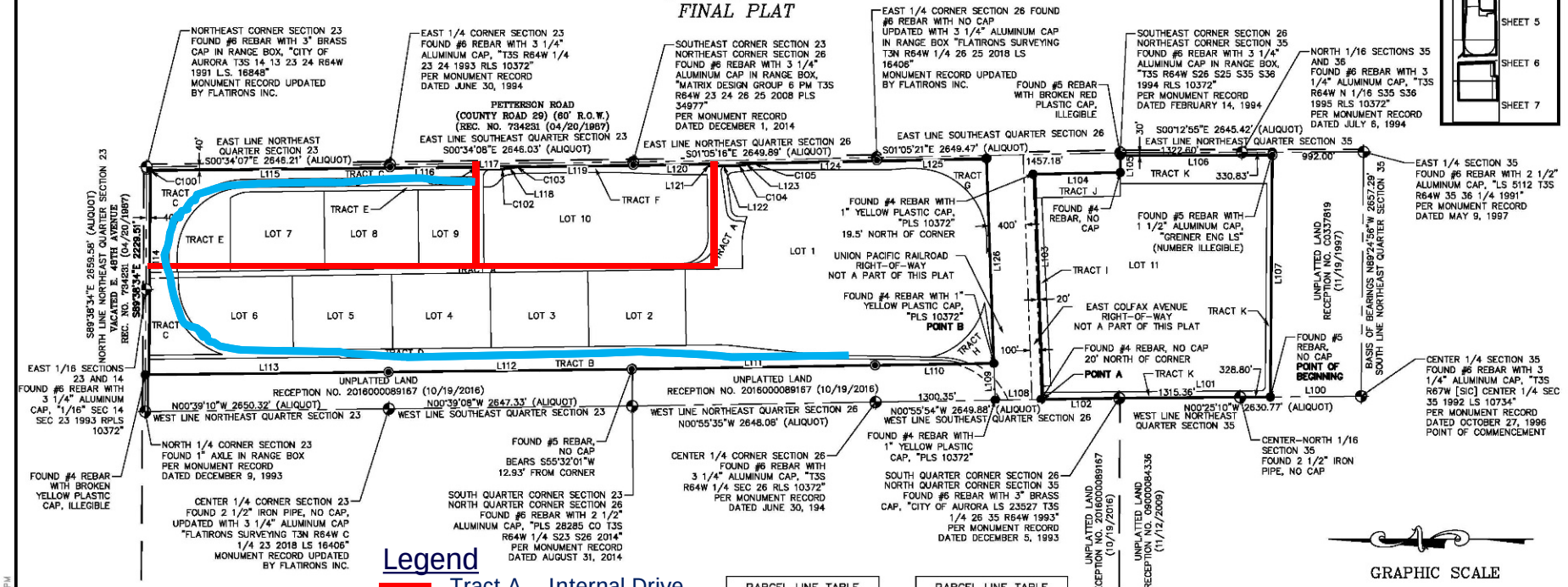
ROCKY MOUNTAIN RAIL PARK FILING NO. 1

PRC2019-00012

LOCATED IN THE EAST HALF OF SECTION 23, THE EAST HALF OF SECTION 26 AND THE NORTHEAST QUARTER OF SECTION 35, TOWNSHIP 3 SOUTH, RANGE 64 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO

SHEET 2 OF 7

FINAL PLAT



Key Map

Legend

Tract A – Internal Drive

Tract D – Future Rail Line

GRAPHIC SCALE

800 0 400 800 1600

(IN FEET)

1 inch = 800 ft.

Legend

- FOUND ALIQUOT MONUMENT AS DESCRIBED
- FOUND MONUMENT AS DESCRIBED
- SET 18" #5 REBAR WITH 1 1/2" ALUMINUM CAP "FLATIRONS SURV 16406"
- BOUNDARY LINE
- ADJACENT PROPERTY LINE
- LOT AND/OR TRACT LINE
- SECTION LINE
- RIGHT-OF-WAY LINE
- EXISTING EASEMENT LINE

PARCEL LINE TABLE		
LINE #	LENGTH	DIRECTION
L100	986.62	N00°25'10"W
L101	1644.15	N00°25'10"W
L102	829.46	N00°55'54"W
L103	2449.56	N87°55'30"E
L104	929.60	S01°04'32"E
L105	184.56	S89°44'09"E
L106	1653.32	S00°12'55"E
L107	2630.74	N89°31'58"W
L108	520.07	N00°55'54"W
L109	400.10	N87°55'30"E
L110	1292.35	N00°55'54"W
L111	2646.15	N00°55'37"W
L112	2647.33	N00°39'08"W
L113	2603.27	N00°39'07"W

PARCEL LINE TABLE		
LINE #	LENGTH	DIRECTION
L114	2196.82	S89°38'33"E
L115	2584.22	S00°34'06"E
L116	923.12	S00°34'07"E
L117	268.06	S00°34'07"E
L118	147.82	S08°23'52"E
L119	1258.36	S00°34'07"E
L120	821.89	S01°05'16"E
L121	20.00	S89°12'16"W
L122	324.35	S01°05'16"E
L123	148.79	S08°12'46"E
L124	1331.48	S01°05'16"E
L125	1191.75	S01°05'20"E
L126	2222.37	S87°55'30"W

CURVE TABLE					
CURVE #	LENGTH	RADIUS	DELTA	CHORD DIRECTION	CHORD LENGTH
C100	35.76	23.00	89°04'27"	S45°06'20"E	32.26
C101	35.13	23.00	87°30'29"	S43°11'07"W	31.81
C102	15.99	117.00	7°49'45"	S04°29'00"E	15.97
C103	11.34	83.00	7°49'45"	S04°29'00"E	11.33
C104	14.55	117.00	7°07'30"	S04°39'01"E	14.54
C105	10.32	83.00	7°07'30"	S04°39'01"E	10.31

OWNERSHIP AND MAINTENANCE TABLE

LOTS	AREA	OWNER	DEDICATIONS	MAINTENANCE	USE
LOT 1	131.55	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 2	19.98	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 3	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 4	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 5	20.00	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 6	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 7	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 8	19.99	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 9	12.49	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 10	54.56	RAIL LAND COMPANY, LLC		OWNER	PUD
LOT 11	121.59	RAIL LAND COMPANY, LLC		OWNER	PUD
SUB TOTAL LOT AREA (AC)	460.42				
TRACTS					
TRACT A	15.34	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	ACCESS, DRN, LA, OS, U
TRACT B	27.86	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT C	24.13	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT D	25.38	RAIL LAND COMPANY, LLC		OWNER	PUD
TRACT E	12.82	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT F	6.90	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT G	9.78	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT H	3.62	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT I	3.66	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT J	5.44	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
TRACT K	18.46	RAIL LAND COMPANY, LLC	RMRPMD	RMRPMD	DRN, LA, OS, U
SUB TOTAL TRACT AREA (AC)	153.39				
TOTAL	613.81				

**RMRPMD = ROCKY MOUNTAIN RAIL PARK METRO DISTRICT
RLC, LLC = RAIL LAND COMPANY, LLC

Overall Boundary

Flatirons, Inc.
Surveying, Engineering & Geomatics
www.FlatironsInc.com
3825 IRIS AVE, STE 395
BOULDER, CO 80301
PH: (303) 443-7001
FAX: (303) 443-9830

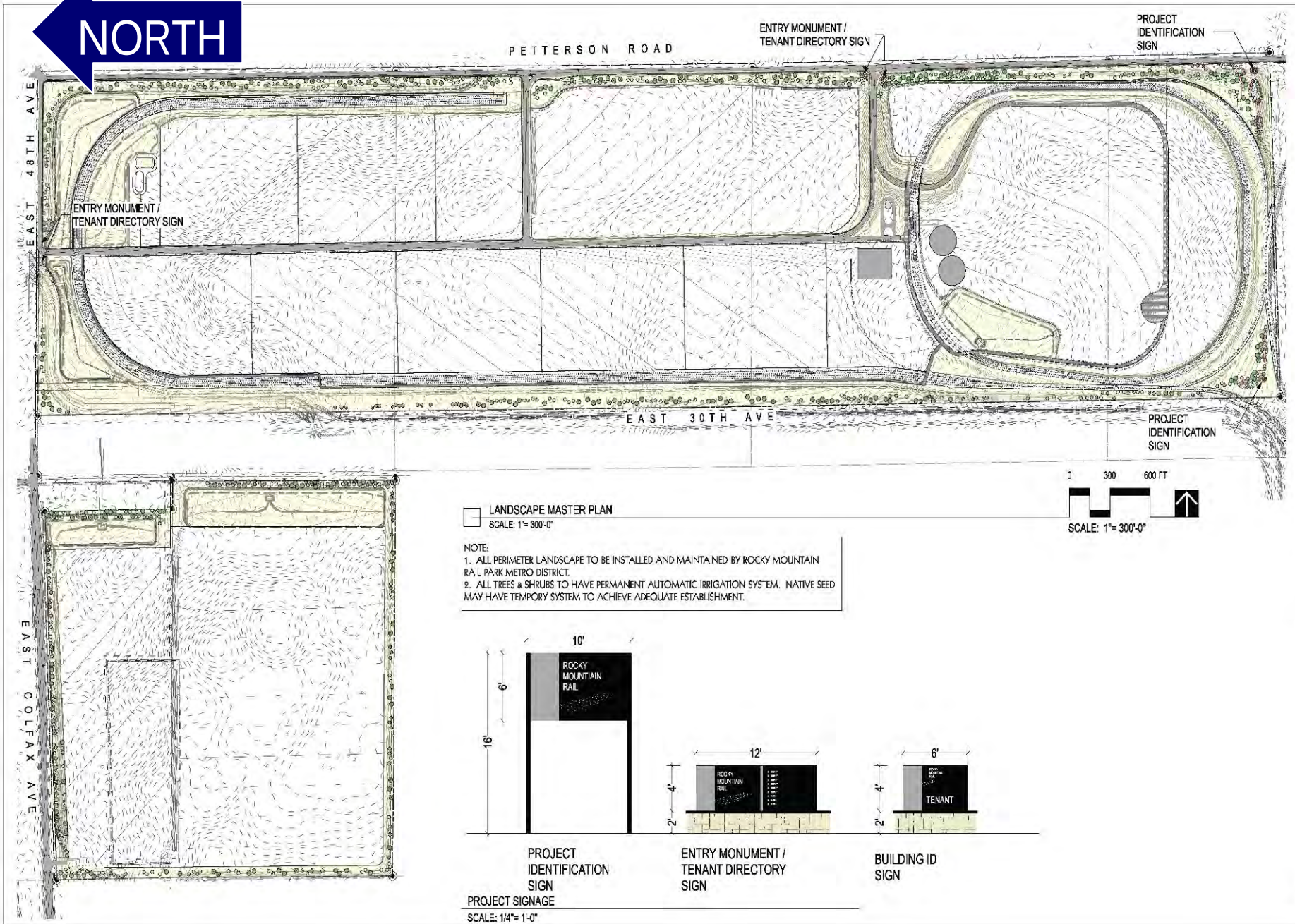
(SEAL)

JOB NUMBER:	18-71,096
DATE:	08/17/2020
DRAWN BY:	M. VOYLES
CHECKED BY:	BO/JZG/JK/ETB

BY:MVOYLES FILE:71096_ROCKY MOUNTAIN RAIL PARK FILING NO. 1.DWG DATE:8/18/2020 1:27 PM

Open Space, Active Recreation, and Parkland Dedication

- Required to provide 30% Open Space in all PUDs
  - PDP provided 162.5 acres of open space
  - FDP is proposing 175 acres
  - Minimum of 10% of each lot required to be open space
- 25% of Open Space is required to be Active Recreation
  - PDP provided 43.1 acres
  - FDP proposes 47.2 acres
    - Interior detached pathways, covered picnic areas, perimeter pathways around detention areas
- Standards and Regs require regional park dedication or cash-in-lieu.
  - Developer is proposing to pay cash-in-lieu for 30.97 acres, which totals $1,539,798
  - Pursuant to DSR, applicant is requesting a phased approach in four payments. This is outlined within the Master Agreement



LANDSCAPE MASTER PLAN
SCALE: 1"= 300'-0"

NOTE:
1. ALL PERIMETER LANDSCAPE TO BE INSTALLED AND MAINTAINED BY ROCKY MOUNTAIN RAIL PARK METRO DISTRICT.
2. ALL TREES & SHRUBS TO HAVE PERMANENT AUTOMATIC IRRIGATION SYSTEM. NATIVE SEED MAY HAVE TEMPORY SYSTEM TO ACHIEVE ADEQUATE ESTABLISHMENT.

PROJECT SIGNAGE
SCALE: 1/4"= 1'-0"

INTERGROUP ARCHITECTS
outside la

NO	DATE	DR	REVISION	CHK	APVD	BY	APVD
DSGN							

ENERTIA CONSULTING

ROCKY MOUNTAIN RAIL PARK

ROCKY MOUNTAIN RAIL PARK
PLANNED UNIT DEVELOPMENT
ADAMS COUNTY, CO

LANDSCAPE CONCEPT

NOT FOR CONSTRUCTION

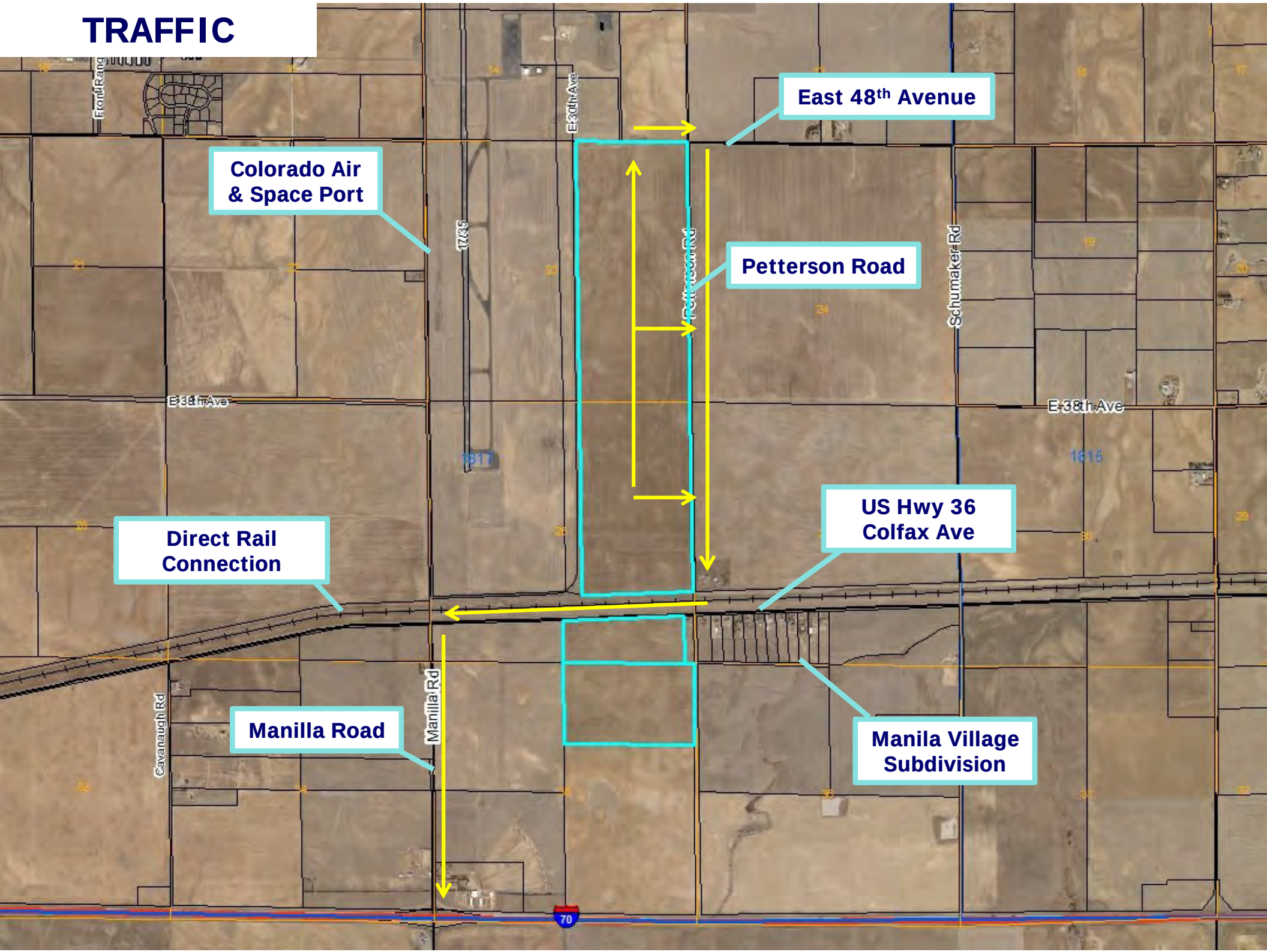
VERIFY SCALE
BAR IS ONE INCH ON ORIGINAL DRAWING.
0 1"

DATE JUNE 30,2020
SHEET 4 OF4

Proposed Zoning Standards

- Loading Areas, Trash Enclosures, & Outdoor Storage
  - Consistent with DSR for I-2 standards
- Architectural Design
  - Massing Breaks every 100-150 feet
  - Building Height
    - 90 Feet for Occupied Structures
    - 150 Feet for Unoccupied Structures
- Setbacks
  - Front (along central private road): 40 feet
  - Side: 20 feet
  - Rear: 20 feet

TRAFFIC


East 48th Avenue
Colorado Air & Space Port
Petterson Road
US Hwy 36 Colfax Ave
Direct Rail Connection
Manilla Road
Manila Village Subdivision
E 38th Ave
E 38th Ave
Schumaker Rd
Manilla Rd
Cavanaugh Rd
70

Services

- Served by Approved Metro District
  - Water
  - Sewer
  - Open Space Management
  - Private Road Management
  - Drainage Facility Management


RAILROAD
CROSSING


AVAILABLE
303 292 3700

Referral Period

Public Notice

Notices sent*	# of Comments Received
35	2*

* Property owners and residents within 2,640 ft were notified

Public Comments

- Drainage concerns and mosquito abatement
- Traffic
- Infrastructure improvements

Referral Agencies

- City of Aurora
  - Applicant will be required to go through Aurora's process, as identified within the MA.
- CDOT
  - Applicant has worked on requirements for entitlement
  - Will need to work with CDOT on access permits when taking any access from State Hwy 36.
- Mile High Flood District (MHFD)
  - Applicant will need to work with MHFD on Crooked Creek improvements
- Colorado Div. of Water Resources
- Colorado Dept. of Public Health & Environment
- Colorado Div. Parks & Wildlife
- Colorado Geological Survey
- Xcel Energy
- Bennett Watkins Fire

Recommendation

Rocky Mountain Rail Park

PRC2019-00012

Staff recommends Approval of the Rocky Mountain Rail Park FDP, Final Plat, Waiver from Subdivision Design Standards and Master Agreement based on 14 Findings-of-Fact, 5 Conditions, and 1 Note.

Recommended Conditions of Approval

1. The applicant shall work with Adams County Facilities and Fleet Management Department on a “through the fence” agreement for future access from the Colorado Air and Space Port to a developable lot along the western edge of the Rocky Mountain Rail Park site. Any future agreement would go to the Board of County Commissioners for approval.
2. The applicant shall work with Adams County Facilities and Fleet Management on a potential agreement for the rail spur, located on Adams County Property, just outside the southwest portion of the site. If an agreement cannot be made, RMRP will need to come up with an alternative solution for the spur, which does not include going through Adams County property.
3. For any future development along the western edge of the Rocky Mountain Rail Park site, screening shall be provided to mitigate the impact between the site and the Colorado Air and Space Port. The applicant shall also provide an acceptable landscape plan for each lot being developed, prior to any issuance of a building permit.

Recommended Conditions of Approval

4. Any development proposed to be greater than 90 feet in height shall work with the Colorado Air and Space Port, as well as the FAA, to ensure any height requirements are met.
5. All Subdivision Improvement Agreements required by the Master Development Agreement shall include the installation of all Open Space and Active Recreation areas directly adjacent to the subject lot(s).

Recommended Note to the Applicant:

1. The applicant shall adhere to all fire, animal, health, zoning, and building codes

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

CASE NO.: PRC2019-00020
CASE NAME: BRANNAN SAND & GRAVEL

TABLE OF CONTENTS

COMMUNITY AND ECONOMIC DEVELOPMENT
DEPARTMENT STAFF REPORT

Board of County Commissioners

September 1, 2020

Case No.: PRC2019-00020	**Case Name: Brannan Sand & Gravel**
Owner's Name:	Pit 10, LLC
Applicant's Name:	Fred Marvel, Brannan Sand & Gravel
Applicant's Address:	2500 E. Brannan Way, Denver, CO 80229
Location of Requests:	2601 W. 60th Avenue
Nature of Requests:	1. Conditional use permit application to allow recycling operations in the Industrial-2 and Industrial-3 zone districts; 2. Conditional use permit application to allow accessory outdoor storage exceeding ten acres in the Industrial-2 and Industrial-3 zone districts; 3. Conditional use permit application to allow stacking of materials up to fifty (50) feet in height and above the height of any screen fencing.
Zone Districts:	Industrial-2, Industrial-3
Comprehensive Plan:	Activity Center
Site Size:	23.6 acres
Proposed Uses:	Heavy Manufacturing or Processing
Existing Use:	(Unpermitted) Heavy Manufacturing or Processing
Hearing Date(s):	**PC: July 9, 2020 / 6:00 p.m.** **BOCC: September 1, 2020 /9:30 a.m.**
Report Date:	July 10, 2020
Case Manager:	Greg Barnes
PC Recommendation:	DENIAL with 14 Findings-of-Fact

SUMMARY OF APPLICATION

Background

Brannan Sand & Gravel is requesting three conditional use permits for a recycling facility use with accessory outdoor storage exceeding ten acres and an outdoor material stacking of up to

fifty (50) feet. The 23.6-acre subject property is located at 2601 W. 60th Avenue. The site is within both the Industrial-2 (I-2) and Industrial-3 (I-3) zone districts.

The applicant has utilized this property without a permit for over 25 years for the processing, storage, and sale of recycled asphalt and concrete material. The material is stockpiled at the site and routed throughout the Denver metropolitan area for various construction projects. In October 1995, Adams County sent a notice of violation informing the property owner that the use was not allowed without a conditional use permit. Subsequently, no conditional use permit was issued, and the facility continued to operate out of compliance with county regulations.

In June 2012, the Board of County Commissioners approved a conditional use permit at 5880 Lipan Street for Brannan Sand & Gravel that allowed the outdoor storage of aggregate material exceeding 10 acres and up to 35 feet in height. As part of that approval, a condition was included to require the operations at the subject property of this request to cease and for the site to be vacated by June 2019. As of July 2020, the applicant has not ceased operations nor vacated the site.

In May 2017, an inspection of the site was conducted by Adams County, the Tri-County Health Department, and the Colorado Division of Public Health & Environment. The team found: that the facility was operating without proper permitting; that the site was used for outdoor storage that was not associated with the business; that the site was being used for a 30-foot tall pile of shingles which constituted an unpermitted disposal of solid waste and potentially may have included asbestos shingles; that the operation had resulted in an illicit discharge into the Clear Creek; and that the facility was storing and stockpiling materials on an adjoining property owned by Adams County.

Over the next few months, Brannan Sand & Gravel began to remedy specific violations discovered at the May 2017 inspection. A settlement agreement was reached in November 2017 between Brannan Sand & Gravel and Adams County. The agreement formalized a timeline for the site to come into compliance. Although the terms of the agreement were initially met by the applicant, a request for extension of deadlines was granted in February 2018. The final step for the applicant to fully comply with the terms of this agreement is approval of the subject conditional use permits. The agreement required that these approvals happen by June 2019. At that time, the County issued a notice of noncompliance to the applicant. The subject applications were received in December 2019.

Site Characteristics and Environmental Considerations:

The subject property has direct access to West 60th Avenue along its southern boundary and approximately 1,700 linear feet of frontage on the public roadway. The site is located approximately 800 feet to the northeast of the intersection of Federal Boulevard and W. 60th Avenue. Federal Boulevard has ramp access onto Interstate-76 just southwest of the site giving the site relatively easy access to the federal highway system.

The site consists of 23.6 acres, of which approximately 90% is designated with I-2 zoning and the remainder is designated with I-3 zoning, which is located on the western edge of the

property. Although there are existing stockpiles on the site that are 30-50 feet in height, the property does not appear to have significant natural terrain.

The site borders the Clear Creek to the north and west. The entire site is impacted by floodplain according to the Federal Emergency Management Agency (FEMA). Approximately 11 acres of the northern and western portions of the site is located within the floodway. This designation by FEMA means that the land area must be reserved to discharge the base flood without cumulatively increasing the water surface elevation more than a designated height. Reservation of the areas is necessary to ensure that there are no increases in upstream flood elevations. The remainder of the property on the southern and eastern portions of the site are within the 100-year floodplain. These areas have a 1% greater chance of flooding each year. Two lakes are located just to the northwest of the subject property.

For the aggregate material to be stored in the floodplain, a Floodplain Use Permit is required. Brannan Sand & Gravel has applied for this permit, which is currently under review by the Mile High Flood District (MHFD). MHFD is developing an updated flood map for this area of Clear Creek that is currently being reviewed by FEMA. The revisions to the flood map are based on modeling that show a wider floodway in the area, which includes the area where the proposed stockpiles are located. To obtain an approved Floodplain Use Permit, Brannan will be required to demonstrate that they can implement measures to mitigate the effects of the stockpiles in the floodplain.

Surrounding Zoning Designations and Existing Use Activity:

Northwest **PUD / I-3** **Industrial / Clear Creek**	**North** **PUD/I-2/I-3** **Industrial / Clear Creek**	**Northeast** **I-3** **Clear Creek**
West **PUD / I-1/ I-3** **Commercial / Industrial**	**Subject Property** **I-2/I-3** **Recycling Facility (Out of Compliance)**	**East** **I-3** **Lake / Right-of-Way**
Southwest **I-3** **RTD Rail Station**	**South** **I-2/I-3** **Vacant**	**Southeast** **I-3** **I-76 Right-of-Way**

Compatibility with the Surrounding Land Uses:

The existing land uses in the area consist mostly of industrial and vacant properties. In 2019, the Clear Creek at Federal Commuter Rail Station became operational and is an important gateway to Southwest Adams County; there are 300 parking spaces intended to serve those who use the Gold Line to access Union Station in Downtown Denver to the south or Wheat Ridge to the west. The introduction of the nearby commuter rail station has resulted in an increase in pedestrian traffic and is expected to serve as a catalyst for more transit-oriented development in the area. The applications for recycling facilities, outdoor storage, and stockpiles of material reaching up to 50 feet in height are incompatible with the surrounding area and particularly the highly trafficked commuter rail station. The request for stockpiles of up to 50 feet are likely to become

windswept and create hazards for pedestrians in the area, while also being clearly visible from the existing Federal Station.

Future Land Use Designation/Goals of the Comp-Plan for the Area

The future land use designation on the property is Activity Center. Per Chapter 5 of the County's Comprehensive Plan, the Activity Center future land use designated areas are intended to allow high-intensity residential, retail, and office development. The Activity Center designated areas are intended to increase employment and increase the tax base, while creating a mix of uses to create a pedestrian environment that is supportive of transit.

The subject property falls within the Southwest Area Plan, the Federal Boulevard Framework Plan, and the Clear Creek Valley Transit Oriented Development Plan. The vision for the Clear Creek at Federal Station is to create a new, vibrant, transit-oriented community amenity within walking distance of the transit station. New retail, employment, entertainment and living opportunities within the envisioned Village Center will serve the needs of the existing community and maintain the area as an employment center for Adams County. The area shall maintain and enhance existing commercial corridors and existing residential neighborhoods. Development in the area is to create new connections with surrounding residential and commercial areas and revitalize older commercial, industrial, or underutilized areas. Mixed-use development and sustainable practices will be encouraged in the Clear Creek at Federal Station. Open space and recreational opportunities will be an important part of the area's development. The activity center is expected to enhance the area's role as a gateway to Southwest Adams County. Planning guidelines for this Area Plan state that the County will discourage land use patterns in transit corridors and around transit stations that may preclude future transit-oriented development. The plan also specifically discourages land consumptive uses related to agriculture or heavy industry such as outdoor storage.

Based on the Adams County Comprehensive Plan's future land designation and the goals of the County's Clear Creek Valley Transit Oriented Development Plan, the subject application does not conform to the County's long-term goals for the region. In addition, the proposed applications may impede future development in the area for high-density mixed-use development with an abundance of open space and recreational options.

Development Standards and Regulations Requirements:

Per Section 3-07-01 of the Adams County Development Standards and Regulations, a conditional use permit is required for recycling facilities in the I-2 and I-3 zone districts. Section 4-10-02-04-09 requires conditional use permits for accessory outdoor storage in excess of ten acres in the I-2 and I-3 zone districts, and for the stacking of materials taller than the height of the required screen fencing. The three applications filed by the applicant are in accordance with these sections.

Chapter 4 of the County's Development Standards and Regulations sets forth specific performance standards to ensure that uses mitigate negative impacts to surrounding areas by requiring site plans that meet aesthetic and functionality requirements to ensure that the use of a property is not detrimental to or incompatible with the surrounding area.

Section 4-10-02-04-07 of the County's Development Standards and Regulations outlines specific performance standards for the recycling facilities use. These standards require an eight-foot-tall screen or security fence to enclose the outdoor storage. The standards require control plans to abate both nuisance and the traffic. The facility will also be required to maintain recordkeeping detailing amounts and types of material stockpiled at the site

Section 4-10-02-04-09 of the County's Development Standards and Regulations outlines specific performance standards for the outdoor storage use. These standards also require all outdoor storage to be enclosed by a screen fence not to exceed eight feet in height. All outdoor storage shall consist of nonhazardous materials as determined by the Colorado Department of Public Health and Environment. All outdoor storage shall be designed with adequate access areas and shall meet all requirements of the local fire district.

Parking requirements are discussed in Section 4-12 of the Adams County Development Standards. All access driveways and required parking spaces are required to be covered with asphalt or concrete. Loading zones are also discussed in these requirements and shall be designed to prevent queueing of traffic on to public roadways.

The site will be expected to conform to the Adams County Development Standards for landscaping. Per Section 4-16-07, a minimum of 10% of the overall site area (approximately 2.4 acres) shall be designated for landscaping. Of this required landscape area, at least 50% (1.2 acres) is to be located along public roadways. Therefore, the applicant shall be expected to provide a 30-foot-wide streetscape buffer along the portions of the property fronting W. 60th Avenue. An additional 1.2 acres of open landscaped area shall be spread throughout the site.

Per Section 4-13 of the Development Standards, the applicant shall conform to the County's Operational Standards. These regulations prevent nuisance to the surrounding properties. The proposed recycling facility and associated outdoor storage will be expected to conform to these regulations to mitigate lighting, vibration, noise, and dust.

The applicant has submitted a site plan and landscape plan that partially conforms to the performance standards for the use. Overall, the proposed development can be improved to better conform with these standards. Should the Board of County Commissioners indicate that the proposed uses are suitable for the property, staff will recommend a continuance of the request to allow staff more time to ensure compliance with the County's Development Standards and Regulations.

PLANNING COMMISSION UPDATE:

The Planning Commission (PC) considered this case on July 9, 2020 and voted (5-0) to recommend denial of the requests. The applicant's representative spoke at the meeting and provided additional information regarding the historical timeline of the facility. The PC expressed concerns regarding the applicant's history of noncompliance. Other noted concerns were related to the negative impact that the existing facilities may have on future development. The PC also noted that the proposed use could relocate to another site to be operational. There was no one from the public to speak in favor or in opposition to the request.

Staff Recommendations:
Based upon the application, the criteria for approval of a conditional use permit, and a recent site visit, staff recommends denial of the request with 14 findings-of-fact.

Recommended Findings-of-Fact:

1. The conditional use is not permitted in the applicable zone district.
2. The conditional use is inconsistent with the purposes of these standards and regulations.
3. The conditional use will not comply with the requirements of these standards and regulations, including but not limited to, all applicable performance standards.
4. The conditional use is incompatible with the surrounding area, not harmonious with the character of the neighborhood, detrimental to the immediate area, detrimental to the future development of the area, and detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
5. The conditional use permit has not addressed all off-site impacts.
6. The site is unsuitable for the proposed conditional use including adequate usable space, adequate access, and absence of environmental constraints.
7. The site plan for the proposed conditional use will not provide the most convenient and functional use of the lot including the parking scheme, traffic circulation, open space, fencing, screening, landscaping, signage, and lighting.
8. The request for outdoor storage is incompatible with the Adams County Comprehensive Plan, does not comply with the minimum zoning requirements of the zone district in which the Conditional Use Permit is to be granted, and does not comply with all other applicable requirements of the Adams County Development Standards and Regulations.
9. Aesthetic concerns have not been taken into consideration during the site design and placement of the outdoor storage.
10. The request for a recycling facility is incompatible with the Adams County Comprehensive Plan, does not comply with the minimum zoning requirements of the zone district in which the Conditional Use Permit is to be granted, and does not comply with all other applicable requirements of the Adams County Zoning and Subdivision Regulations.
11. The applicant has not documented his ability to comply with the health standards and operating procedures as provided by the Colorado Department of Public Health and Environment, Tri-County Health Department, Fire District, and other relevant agencies.
12. The proposed facility will cause significant traffic congestion or traffic hazards.
13. The request is incompatible with the surrounding area.
14. The site will impact health and welfare of the community based upon specific recycling facility design and operating procedures.

PUBLIC COMMENTS

Notices Sent	Number of Responses
162	2

Property owners and residents within 1,500 feet of the site were notified of the subject request. As of writing this report, staff has received two responses regarding the application. ARMOS Investments expressed concern that the proposed use may have a negative impact on the use of

their property. They wished to remain updated on the proposed timeline of the use, if approved. In addition, staff received one comment from Dan Micek in support of the request.

COUNTY AGENCY COMMENTS

Upon receipt of these applications, staff identified concerns that the requested conditional use permits may not be compatible with the surrounding area. Future development surrounding the Clear Creek at Federal Station may be negatively affected by the proposed stockpile heights and outdoor storage. In addition, staff identified that additional landscaping and screening techniques may improve the application. Although compliance with the County's Development Standards is a criterion for approval, it was noted that full conformance with these standards would not remedy the existing concerns regarding compatibility and land use. Rather than ask the applicant to invest further in an application that will not receive a recommendation of approval, staff proposed scheduling the hearing with a recommendation of denial. Should the Planning Commission and Board of County Commissioners determine that the use may be compatible with surrounding area and will not be a detriment to future development, then staff will ask the Board for a continuance on this case to work with the applicant on engineering and landscaping design of the site.

REFERRAL AGENCY COMMENTS

During the referral process, the Tri-County Health Department identified concern with fugitive dust from the proposed facility. No other concerns were noted from those referral agencies that were notified.

Responding with Concerns:
Tri-County Health Department

Responding without Concerns:
Colorado Department of Natural Resources, Division of Water Resources
Colorado Department of Transportation
City of Arvada
Denver Water
Adams County Fire
Regional Transportation District
Xcel Energy

Notified but not Responding / Considered a Favorable Response:
Adams County Sheriff
Arvada Fire District
Berkeley Neighborhood Group
Berkeley Sanitation District
Century Link
City of Westminster
Colorado Geologic Survey
Colorado Division of Mining & Reclamation Safety
Comcast
Crestview Water & Sanitation

Goat Hill Neighborhood
Mapleton School District
Metro Wastewater Reclamation
Mobile Gardens
North Lincoln Water & Sanitation District
North Pecos Water & Sanitation District
Northridge Estates at Gold Run HOA
Pecos Logistics Park Metropolitan District
Perl Mack Neighborhood
Pomponio Terrace Metropolitan District
The TOD Group
Union Pacific Railroad
US Postal Service
US Environmental Protection Agency
Westminster Fire District
Westminster School District #50

Legend

- Railroad
- Major Water
- Zoning Line
- Sections

Brannan Sand & Gravel

PRC2019-00020

N

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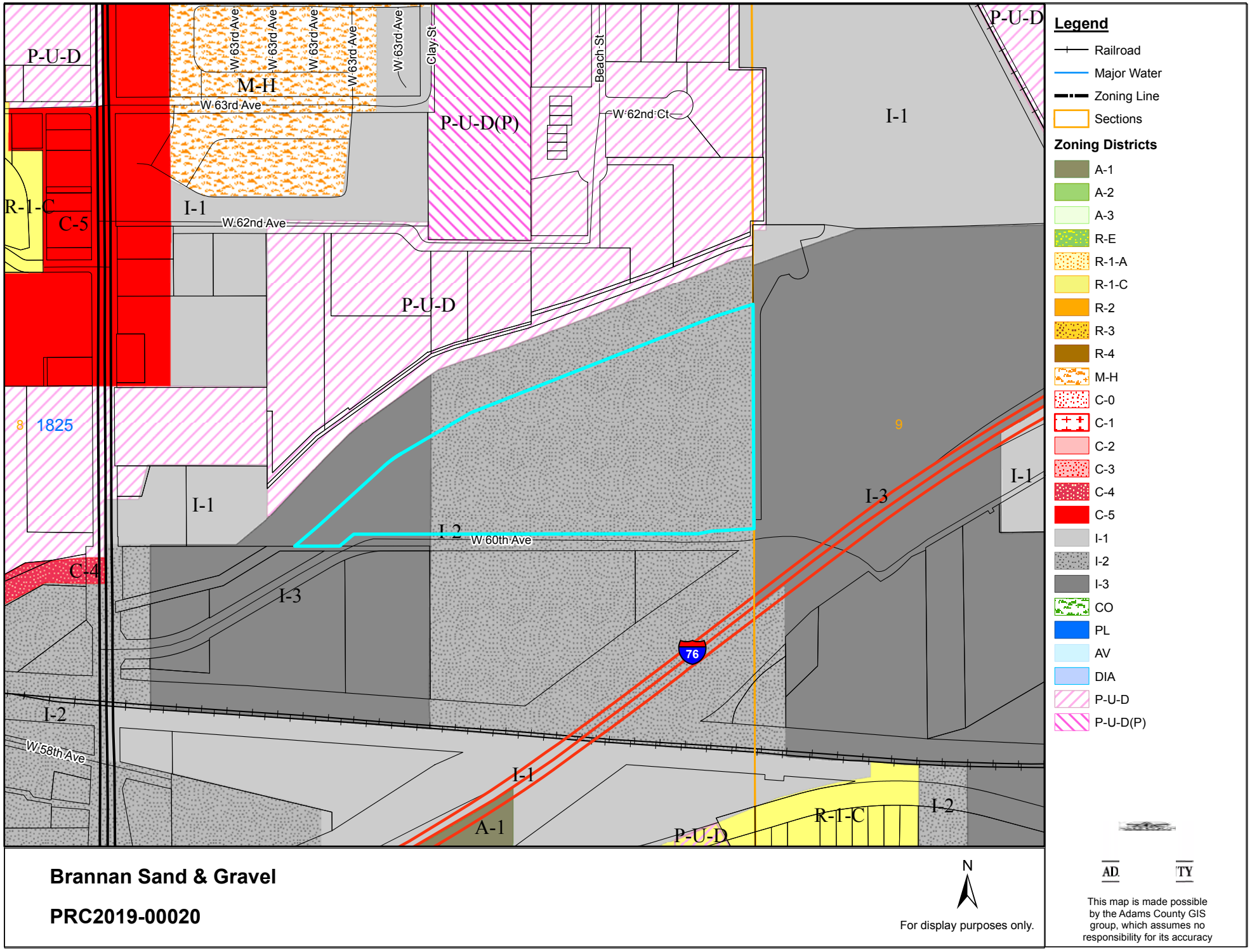

Brannan Sand & Gravel

PRC2019-00020

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AD TY

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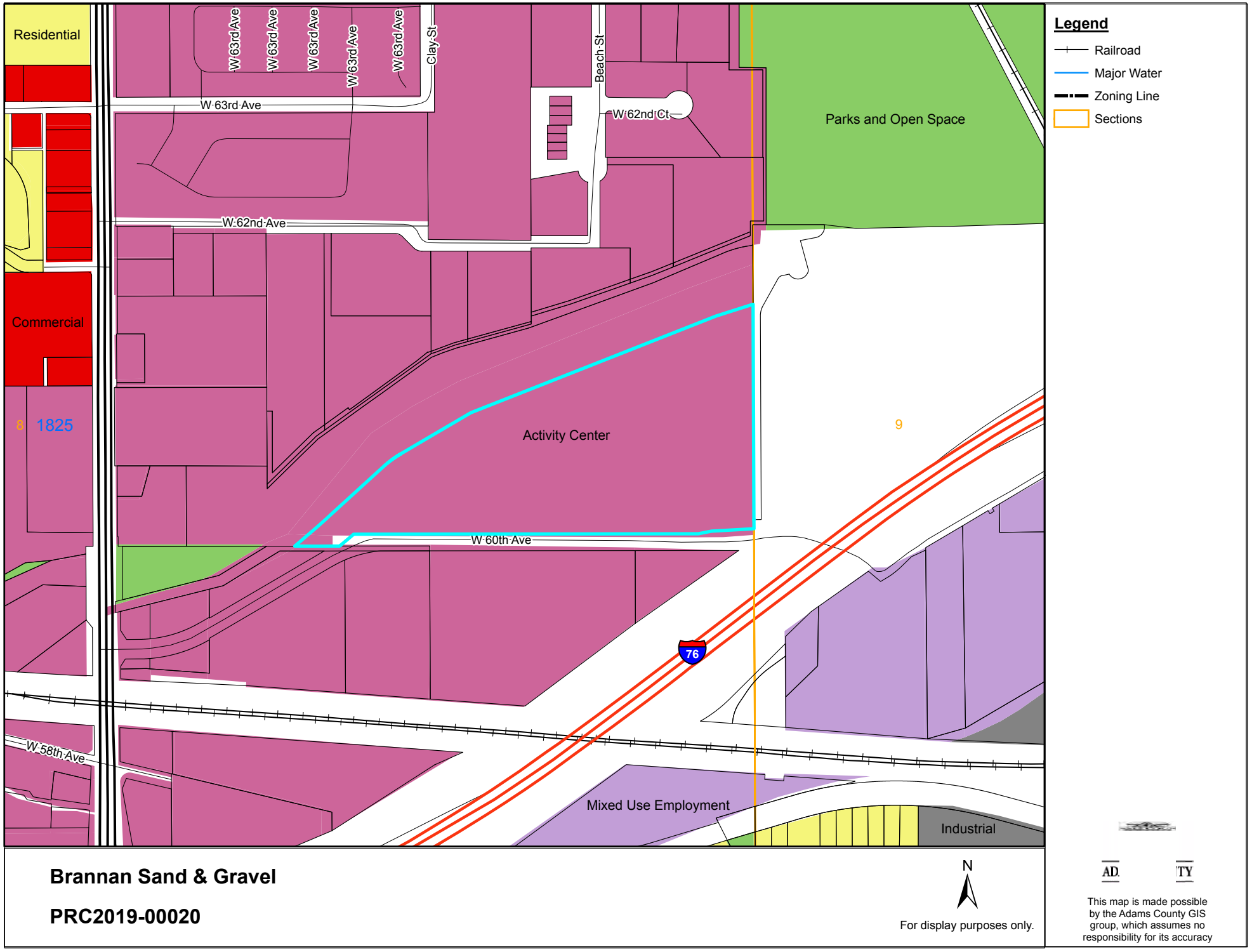

Brannan Sand & Gravel

PRC2019-00020

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BRANNAN
Companies

26 April 2019

Adams County Economic and Community Development
4430 South Adams County Parkway
Brighton, Colorado 80601

Re: Submittal of Land Use Application, Pit 10, 2601 West 60th Avenue

Dear Adams County officials:

On behalf of Pit 10, LLC, please find under this cover an application related to 2601 W. 60th Avenue in unincorporated Adams County.

The Applicant, as Brannan Sand and Gravel, has operated in this area of Adams County for many years, and on the specific subject property for no less than 20 years. The property at 2601 W. 60th Avenue is zoned for industrial use, in the I-2 zone district with a small piece of I-3 zoning at its western edge. Based on Pit 10's recent work with Adams county related to this land – including code enforcement communications and more recently a Conceptual Review Meeting in November 2018 – we agree that formal plan review will alleviate concerns about appropriate site improvements, the scope and timing of transition plans, and the application of County comprehensive plan aspirational goals for the general vicinity.

While the County staff and plans articulate a general desire to redevelop the area, and the Applicant has engaged with experts on this prospect, it is apparent that the regulatory status of 2601 West 60th Avenue as a jurisdictional floodplain is a substantial impediment to any change in the long-term economic use of this site. The site is currently undergoing floodplain analysis, both as part of a larger study of Clear Creek and on a site-specific basis. The immediate site-specific use of the property is under study by ICON Engineering and will be packaged as an Adams County floodplain use permit application as soon as available. The resolution of Clear Creek floodplain mapping is critical to effective long-term grading and drainage plans, as well as identification of riverbank stabilization and channelization opportunities in conjunction with Urban Drainage or other agencies.

The application process for the existing/proposed land use at 2601 West 60th Avenue is intended to define expectations for the immediate future of the site. It is not a redevelopment plan, nor does the Applicant intend to determine the appropriate future use of the property at this time. After careful deliberation, we believe that subdivision and other steps toward redevelopment are most appropriately addressed in a separate process. The current process is directed at assessing compliance with County industrial zoning standards and specifically reviewing operations that will enable and actively manage the transition to future land uses.

It is significant that the site has operated in more or less its present form for many years, with the involvement of Adams County officials along the way. That ongoing use informs our understanding of the terms and application of Adams County regulations, as noted in the attached narrative. But it is more importantly emblematic of Brannan's positive working relationship with the County, which we endeavor to continue. Based on Adams County direction, Brannan has invested nearly $2 million in grading and material processing work in the last two years, and we have modified operations to reduce stockpile footprint and height. The process envisioned by the enclosed application will allow us to continue in this direction, making operations more compact and compliant with zoning plans.

Thank you in advance for the work of Adams County staff and the boards and commissions.

Sincerely,

Fred Marvel, Manager
for Pit 10, LLC

2500 East Brannan Way | Denver | CO 80229 | 303.534.1231 Tel | 303.534.1236 Fax
www.brannan1.com

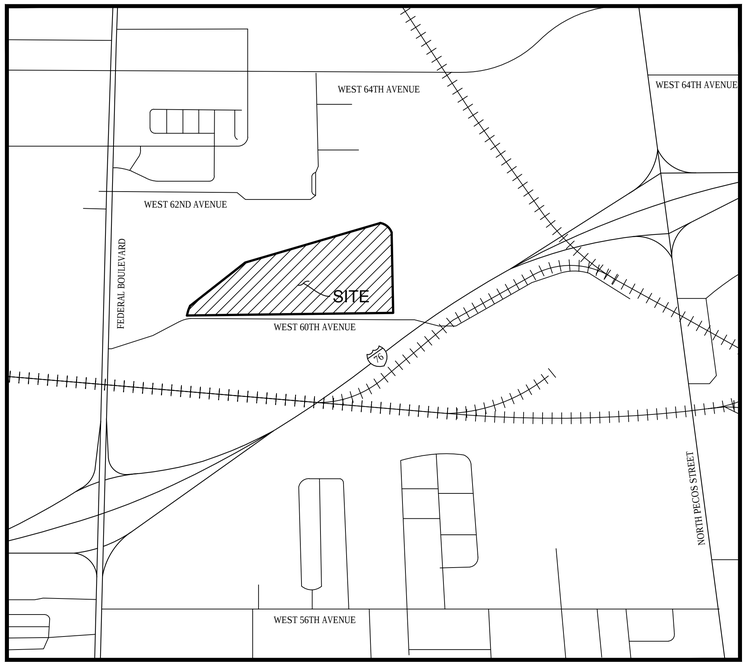
CONDITIONAL USE PERMIT - PIT R

BRANNAN SAND AND GRAVEL
2601 WEST 60TH AVENUE
SITUATED IN THE NORTHEAST CORNER OF SECTION 8,
TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH
PRINCIPAL MERIDIAN
COUNTY OF ADAMS, STATE OF COLORADO

PRIVATE IMPROVEMENT CONSTRUCTION PLANS

GENERAL NOTES:

1. A PRE-CONSTRUCTION MEETING IS REQUIRED PRIOR TO THE COMMENCEMENT OF CONSTRUCTION. TO SCHEDULE A PRE-CONSTRUCTION MEETING CONTACT THE ADAMS COUNTY CONSTRUCTION INSPECTOR SUPERVISOR AT 720-523-6965.
2. ALL CONCRETE CURB, GUTTER AND WALK MUST BE POURED MONOLITHICALLY USING 4,500 psi CONCRETE WITH FIBER MESH.
3. ALL MATERIAL SUBMITTALS MUST BE APPROVED, STAMPED AND SIGNED, BY THE ENGINEER OF RECORD AND, SUBMITTED TO THE ADAMS COUNTY CONSTRUCTION INSPECTOR FOR APPROVAL PRIOR TO CONSTRUCTION/INSTALLATION.
4. THE CONTRACTOR IS REQUIRED TO SUBMIT COPIES OF ALL CONCRETE AND ASPHALT TICKETS TO THE ADAMS COUNTY CONSTRUCTION INSPECTOR.
5. THE CONTRACTOR IS RESPONSIBLE FOR ALL QUALITY CONTROL TESTING AND, IS REQUIRED TO SUBMIT ALL TEST RESULTS TO THE ADAMS COUNTY CONSTRUCTION INSPECTOR.
6. THE CONTRACTOR IS REQUIRED TO REMOVE A MINIMUM OF TWO (2) FEET OF EXISTING ASPHALT FOR ALL CURB AND GUTTER REPLACEMENT.
7. ALL UTILITY CUTS IN EXISTING STREETS ARE REQUIRED TO BE BACKFILLED WITH FLOWFILL AND, PATCHED WITH A MINIMUM OF 9-INCH ASPHALT PATCH.
8. A COPY OF THE GEOTECHNICAL REPORT SPECIFYING THE PAVEMENT THICKNESS DESIGN MUST BE SUBMITTED FOR REVIEW.
9. PERMITS WILL BE REQUIRED FOR THE INSTALLATION OF ALL UTILITIES. THE DEVELOPER/CONTRACTOR/ENGINEER, MUST SUPPLY THE LINEAL FOOTAGES AND THE NUMBER OF SERVICE CUTS REQUIRED FOR ALL UTILITIES.
10. PERMITS WILL BE REQUIRED FOR THE INSTALLATION OF ALL CONCRETE AND ASPHALT FACILITIES. PRIOR TO THE ISSUANCE OF THESE PERMITS, THE DEVELOPER/CONTRACTOR/ENGINEER, MUST SUPPLY THE SQUARE YARDAGE/SQUARE FOOTAGES OF ALL CONCRETE AND ASPHALT BEING INSTALLED.
11. THE SIA MUST BE COMPLETED WITH APPROPRIATE COLLATERAL, ALONG WITH THE PROPOSED PLAT, PRIOR TO THE ISSUANCE OF ANY ROW ACCESS/CONSTRUCTION PERMIT.
12. NO C.O.'S WILL BE ISSUED FOR ANY BUILDING CONSTRUCTION UNTIL ALL ROW IMPROVEMENTS HAVE BEEN COMPLETED AND HAVE BEEN GRANTED PRELIMINARY ACCEPTANCE.
13. UPON COMPLETION OF ALL CONSTRUCTION, A DRAINAGE CERTIFICATION LETTER, AND APPROPRIATE AS-BUILT CONSTRUCTION DRAWINGS AND INFORMATION WILL BE REQUIRED. THIS LETTER WILL BE STAMPED AND SIGNED BY THE ORIGINAL DESIGN ENGINEER.



VICINITY MAP
SCALE: 1"=600'

BENCHMARK:

PER THE ADAMS COUNTY DATASHEET FOR WEST ADAMS COUNTY DENSIFICATION STATION NAME 95.0244, STATION NUMBER: 0244, A 3-1/4" ALUMINIUM DISK SET IN 6" PVC PIPE W/LOGO CAP, STAMPED "95.0244 1995 3S68W S17" LOCATED SOUTHWEST OF THE INTERSECTION WEST 56TH AVENUE AND ZUNI STREET. ELEVATION 5271.33 NAVD 1988 DATUM.

NOTE:

PUBLIC IMPROVEMENTS SHALL CONFORM TO ADAMS COUNTY STANDARDS AND SPECIFICATOINS AND LATEST EDITION OF COLORADO DEPARTMENT OF TRANSPORTATION STANDARD SPECIFICATIONS.

LEGEND

EX STORM INLET
EX STORM SEWER W/MH — ST
EX SANITARY SEWER W/MH — SS
EX WATER — W
EX OVERHEAD ELECTRIC — OE
EX UTILITY POLE
PROPERTY BOUNDARY
PR SIDEWALK
EX CONTOURS — 5221 — 5220
PR CONTOURS — 5220 — 5221

SHEET INDEX

811 Know what's below. Call before you dig.

CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

DEVELOPER:
BRANNAN SAND AND GRAVEL COMPANY, LLC
2500 EAST BRANNAN WAY
DENVER, CO 80229
T. 1-303-534-1231

HARRIS KOCHER SMITH
1120 Lincoln Street, Suite 1000
Denver, Colorado 80203
P: 303.623.6300 F: 303.623.6311
HarrisKocherSmith.com

ISSUE DATE: 11-25-2019	PROJECT #: 190915
DATE	REVISION COMMENTS

Filepath: P:\190915\ENGINEERING\CONDITIONAL USE PERMIT\PRIVATE\PRIVATE COVER.DWG Layout: LAYOUT1
LTScale: 1
Plotted: MON 05/04/20 3:01:05P By: Mark West

LEGAL DESCRIPTION: (FROM CLIENT)

A PARCEL OP LAND LYING IN THE NORTHEAST 1/4 OF SECTION 8, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:
BEGINNING AT THE NORTHEAST CORNER OF SAID SECTION 8, THENCE SOUTH OO DEGREES 07 MINUTES 03 SECONDS EAST, 1650.60 FEET ALONG THE EAST LINE OF SAID SECTION 8 TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND AS DESCRIBED IN BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS, SAID POINT BEING THE TRUE POINT OF BEGINNING;
THENCE SOUTH OO DEGREES 07 MINUTES 03 SECONDS EAST ALONG THE EAST LINE OF SAID SECTION 8 920.29 FEET TO A POINT ON THE NORTH LINE OF THAT PARCEL OP LAND AS DESCRIBED IN BOOK 3374, PAGE 318, ADAMS COUNTY RECORDS,
THENCE SOUTH 86 DEGREES 54 MINUTES 2O SECONDS WEST ALONG SAID NORTH LINE 169.81 FEET;
THENCE SOUTH 78 DEGREES 58 MINUTES 16 SECONDS WEST ALONG SAID NORTH LINE 56.02 FEET TO THE NORTH LINE OF THAT PARCEL OF LAND AS DESCRIBED IN BOOK 3432, PAGE 154, ADAMS COUNTY RECORDS;
THENCE NORTH 89 DEGREES 58 MINUTES 13 SECONDS WEST ALONG SAID NORTH, LINE 1411.7O FEET;
THENCE SOUTH 49 DEGREES 53 MINUTES 18 SECONDS WEST ALONG THE NORTHWESTERLY LINE OF SAID PARCEL OF LAND DESCRIBED IN BOOK 3432, PAGE 154 A DISTANCE OF 77.56 FEET TO THE EAST-WEST CENTERLINE OF SAID SECTION 8;
THENCE NORTH 89 DEGREES 58 MINUTES 13 SECONDS WEST ALONG SAID EAST-WEST CENTERLINE 183.64 FEET MORE OR LESS TO THE SOUTHERLY LINE OF THAT PARCEL OF LAND AS DESCRIBED IN BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS;
THENCE NORTHEASTERLY ALONG SAID SOUTHERLY LINE THE FOLLOWING SIX COURSES:
1. NORTH 49 DEGREES 25 MINUTES 25 SECONDS EAST, 122.50 FEET;
2. NORTH 47 DEGREES 42 MINUTES 36 SECONDS EAST, 356.79 FEET;
3. THENCE ALONG A CURVE TO THE RIGHT HAVING A RADIUS OF 433.51 FEET AND A CENTRAL ANGLE OF 11 DEGREES 59 MINUTES 07 SECONDS;
4. NORTH 59 DEGREES 41 MINUTES 43 SECONDS FAST, 331.34 FEET;
5. NORTH 68 DEGREES 33 MINUTES 27 SECONDS EAST, 1080.62 FEET;
6. NORTH 72 DEGREES 24 MINUTES 16 SECONDS EAST, 155.30 FEET TO THE TRUE POINT OF BEGINNING.
NOTE: THE ABOVE LEGAL DESCRIPTION WAS PREPARED BY SELLARDS & GRIGGS, INC. , JOB NO. 93-085-021,

BASIS FOR BEARINGS:

THE EAST LINE OF THE NORTHEAST ONE-QUARTER OF SECTION 8, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, BEARS SOUTH OO°13'39" EAST (BY PUBLISHED COORDINATES), TAKEN FROM THE CDOT, RIGHT-OF-WAY PLANS PROJECT NO: STE CO12O-019, ON FILE IN LAND SURVEY PLATS, BOOK 1, PAGE 4952, RECEPTION NO. 2017-187, ADAMS COUNTY RECORDS.
THIS DRAWING IS IN STATE PLANE COORDINATES (GROUND) NAD83 CENTRAL ZONE
THE COMBINED SCALE FACTOR IS: 0.99979199I (1/X=1.OOO2O852).
ALL BEARINGS SHOWN HEREON ARE RELATIVE (ROTATED) THERETO. MONUMENTS EXIST AS SHOWN HEREON.

NOTICE:

ACCORDING TO COLORADO LAW YOU MUST COMMENCE ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY WITHIN THREE YEARS AFTER YOU FIRST DISCOVER SUCH DEFECT. IN NO EVENT MAY ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY BE COMMENCED MORE THAN TEN YEARS FROM THE DATE OF THE CERTIFICATION SHOWN HEREON.

THE LINEAL UNITS USED AND SHOWN HEREON IS U. S. SURVEY FOOT.

THE FENCE DIMENSION(S) INDICATE ON WHICH SIDE OF THE LINE THE FENCE IS ON.

THE CLIENT REQUESTED THAT RIGHT-OF-WAY BE SHOWN. THE CLIENT WAS MADE AWARE THAT EASEMENTS WOULD NOT BE SHOWN EXCEPT WHERE DOCUMENTATION WAS PROVIDED TO THE SURVEYOR. THIS SURVEY DOES NOT CONSTITUTE A TITLE SEARCH BY R.W. BAYER & ASSOCIATES, INC. OF THE PROPERTY SHOWN AND DESCRIBED HEREON TO DETERMINE OWNERSHIP, MINERAL INTEREST OWNERSHIP, COMPATIBILITY OF THIS DESCRIPTION WITH THOSE OF ADJACENT TRACTS OF LAND OR RIGHTS-OF-WAY, DEDICATIONS, EASEMENTS OR ENCUMBRANCES OF RECORD AFFECTING THIS TRACT OF LAND.

THIS MAP IS NOT INTENDED TO REPRESENT A BOUNDARY SURVEY OR LAND SURVEY PLAT. IT IS ONLY INTENDED TO DEPICT THE ATTACHED LEGAL DESCRIPTION.

THIS PARCEL OF LAND LIES WITHIN ZONE AE (FLOODWAY AND AREAS INUNDATED BY THE 1% ANNUAL CHANCE FLOODPLAIN (100 YEAR FLOOD) AS DELINEATED IN THE F.E.M.A., FLOOD INSURANCE RATE MAP, MAP NUMBER 08001C0592H, MAP REVISED MARCH 05, 2007. THE FLOODWAY AND FLOODPLAIN LINES SHOWN HEREON ARE FROM THE CAD FILE PREPARED BY ICON ENGINEERING, INC., CAD FILE NAME BRANNON-FW-RESULTS.dwg.

BENCHMARK: PER THE ADAMS COUNTY DATASHEET FOR WEST ADAMS COUNTY DENSIFICATION STATION NAME: 95.0244, STATION NUMBER: 0244, A 3-1/4" ALUMINUM DISK SET IN 6" PVC PIPE W/LOGO CAP, STAMPED "95.0244 1995 3968W S17" LOCATED SOUTHWEST OF THE INTERSECTION WEST 56TH AVENUE AND ZUNI STREET. ELEVATION 5271.33 NAVD 1988 DATUM.

N
W E
S
0 30' 60' 120'

SCALE: 1"=60'

LEGEND

x — x — DENOTES: FENCE LINE
DENOTES: CONCRETE
P — P — DENOTES: OVERHEAD POWER LINE

N. E. COR. SEC 8, T. 3S., R. 68W.
(NOT FOUND)

EAST LINE N.E. 1/4 SEC. 8
(BASIS FOR BEARINGS)

S00°13'39"E 1650.56'
S00°13'39"E 2640.85'

BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS

ZONE AE (FLOODWAY)
CLEAR CREEK

N72° 17' 40"E
155. 30'

SOUTH LINE BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS

MANHOLE UNKNOWN
RIM E. = 5198.10

MANHOLE UNKNOWN
RIM E. = 5198.40

POWER POLE

GRAVEL ROAD

1080. 62'

N68°26'51"E

TOE OF BAR
TOP OF BERM
TOE OF BERM
TOE STOCKPILE

CONTOURS SHOWN ARE APPROXIMATE (STOCKPILE AREA)

CONTOURS SHOWN ARE APPROXIMATE (LARGE STOCKPILE AREA)

MANHOLE UNKNOWN
RIM E. = 5198.65

S00°13'39"E 980.29'

N59° 33' 07"E 331.34'

Δ = 011°59'07"
R = 433/510'
L = 90/68'
Ch=N53°35'33"E
90.52' (D&M)

ZONE AE (100 YEAR FLOODPLAIN)

BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS

366. 79'

N47°36'00"E

INV. = 5196.36

15" PVC

INV. = 5197.37

MANHOLE UNKNOWN
RIM E. = 5199.36

FOUND 3-1/4" ALUMINUM CAP, CDOT, P.L.S. 24673

NORTH LINE BOOK 3374, PAGE 318, ADAMS COUNTY RECORDS

NORTH LINE BOOK 3432, PAGE 154, ADAMS COUNTY RECORDS (NOTE: THIS LINE DESCRIBED AS 50 FEET NORTH OF THE NORTH-SOUTH CENTERLINE SECTION 8)

6' CHAINLINK FENCE W/3-STRAND BARBED-WIRE

NOTE: FEATURES BETWEEN FENCE AND ROADWAY NOT FIELD LOCATED

S78°51'40"W
55. 78'

S86°47'44"W 169. 81'

N49°18'49"E
121. 80'

S89°56'40"W
183. 57'

S49°46'42"W
77. 52'

S89°56'40"W 306. 60'

S89°55'55"W 1104. 85'

NORTH EDGE OF ROADWAY

S89°55'55"W 1329. 34'

BOOK 3432, PAGE 154, ADAMS COUNTY RECORDS

BOOK 3432, PAGE 154, ADAMS COUNTY RECORDS

WEST 60TH AVENUE

SOUTH LINE S.E. 1/4 N.E. 1/4 SEC. 8

BOOK 3374, PAGE 318, ADAMS COUNTY RECORDS

MANHOLE UNKNOWN
RIM E. = 5202.23

POWER POLE
MANHOLE UNKNOWN
RIM E. = 5201.21

FOUND 2-1/2 ALUMINUM CAP, P.L.S. 28285, 0.2' BELOW GROUND

C-E 1/16 COR. SEC 8, T. 3S., R. 68W.
(S.W. COR. S.E. 1/4 N.E. 1/4 SEC. 8)
(FOUND 3-1/4" ALUMINUM CAP, P.L.S. 13258)

E. 1/4 COR. SEC 8, T. 3S., R. 68W.
(S.E. COR. N.E. 1/4 SEC. 8)
(FOUND #6 REBAR, UPGRADED W/ 3-1/4" ALUMINUM CAP, BAYER, P.L.S. 6973, 2017, 0.4' BELOW GROUND)

7790 CORPORATION TRACT
(RECEPTION NO. 972191, ADAMS COUNTY RECORDS)

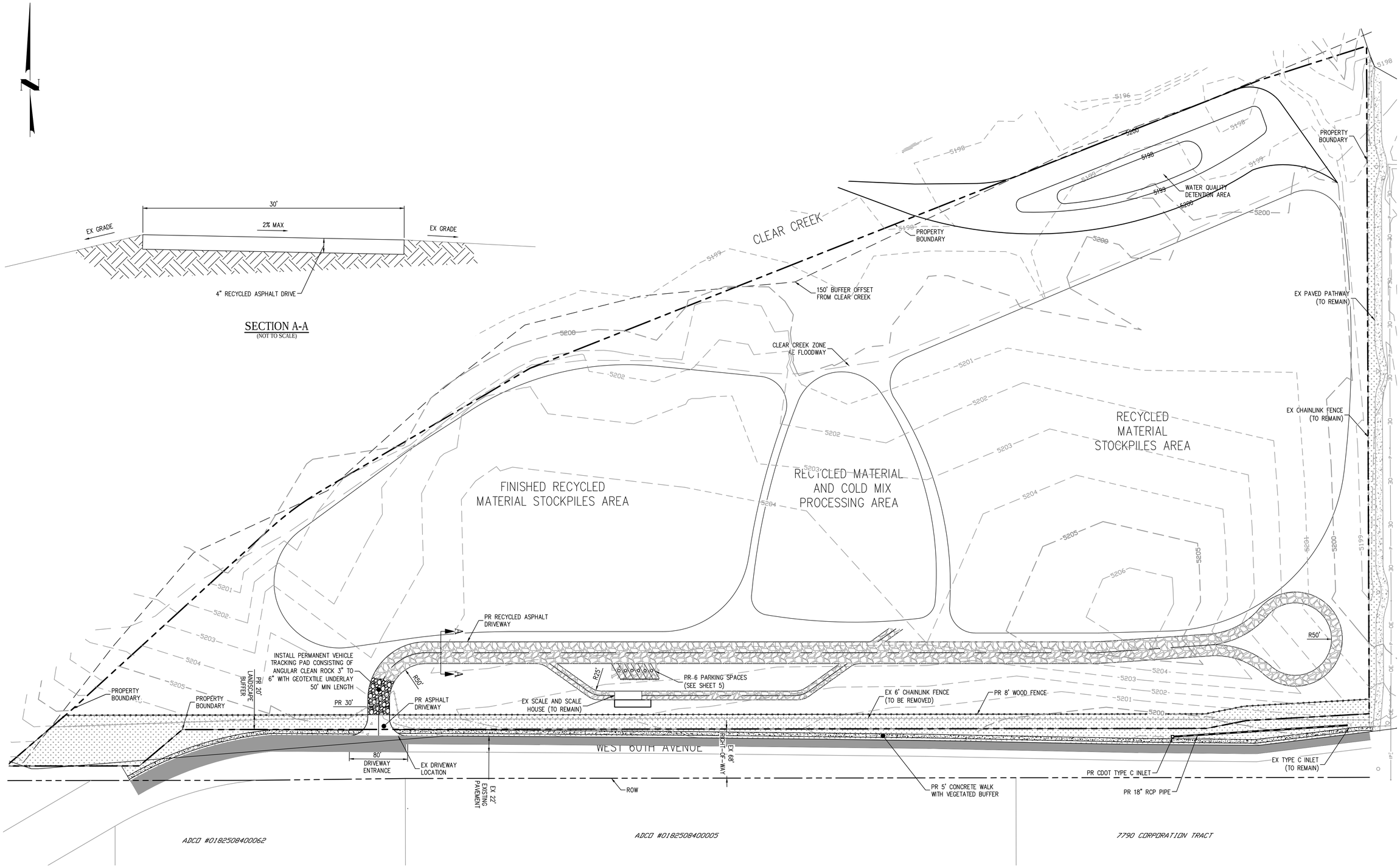
ADCO #0182508400063
ADCO #0182508400064
ADCO #0182508400005
ADCO #0182508400062

R.W. BAYER & ASSOCIATES, INC.
2090 EAST 104TH AVENUE, SUITE 200
THORNTON, COLORADO 80233-4316
(303) 452-4433 rwbsurveying@hotmail.com

CAD FILE: B18134/B18134.DWG REVISIONS: 09-12-2018 ADD FLDWAY EXISTING & ADDITIONAL TOPO SOUTH OF FLDWAY LINE / 09-28-2018 ADDED NEW TOPO IN N.W. CORNER /

PIT R TOPOGRAPHIC MAPPING
PART OF NORTHEAST ONE-QUARTER OF SECTION 8, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO.

SCALE:	DATE:	DRW BY:	CKD BY:	PROJ. NO:
1"=60'	JULY 18, 2018	G.A.B.	R.B.	2018-134
BOOK: 698/703	PAGE: 137/46	FILE NO: 8-38-218L		SHEET: 1 OF 1



811 Know what's below. Call before you dig.

CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

60 0 60 120
SCALE: 1" = 60'

DESIGNED BY: DESIGNER
CHECKED BY: REVIEWER
DRAWN BY: DRAFTER

HARRIS KOCHER SMITH
1120 Lincoln Street, Suite 1000
Denver, Colorado 80203
P: 303.623.6300 F: 303.623.6311
HarrisKocherSmith.com

BRANNAN SAND AND GRAVEL

CONDITIONAL USE PERMIT - PIT R
SITE PLAN

ISSUE DATE: 11-25-2019 | PROJECT #: 190915

DATE	REVISION COMMENTS

PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO. 3

LEGEND

PROPERTY LINE
EXISTING RIGHT-OF-WAY
EXISTING CONTOURS 5229 5230
PROPOSED CONTOURS 5229 5230
PROPOSED STORM SEWER
PROPOSED DRAINAGE BASIN
LANDSCAPE AREA ADRAIN
SURFACE FLOW DIRECTION
EMERGENCY OVERFLOW LOCATION

BASIN DESIGNATION — OS 1 — 5-YR RATIONAL (POST-PROJECT) C COEFFICIENT
BASIN SIZE IN ACRES — AREA 1.23 AC — MINOR 0.45 MAJOR 0.67 — 100-YR RATIONAL (POST-PROJECT) C COEFFICIENT
1 BASIN DESIGN POINT

N

RUNOFF SUMMARY TABLE

BASIN	DESIGN POINT	AREA (AC)	IMPERVIOUS %	Q_5 (CFS)	Q_{100} (CFS)
Road (exist)	1	3.49	12.3	0.39	2.56
Road (prop)	1	3.49	16.9	0.60	3.09
Site (exist)	2	21.18	2.7	0.35	10.18
Site (prop)	2	21.18	2.7	0.35	10.18

DETENION POND SUMMARY TABLE

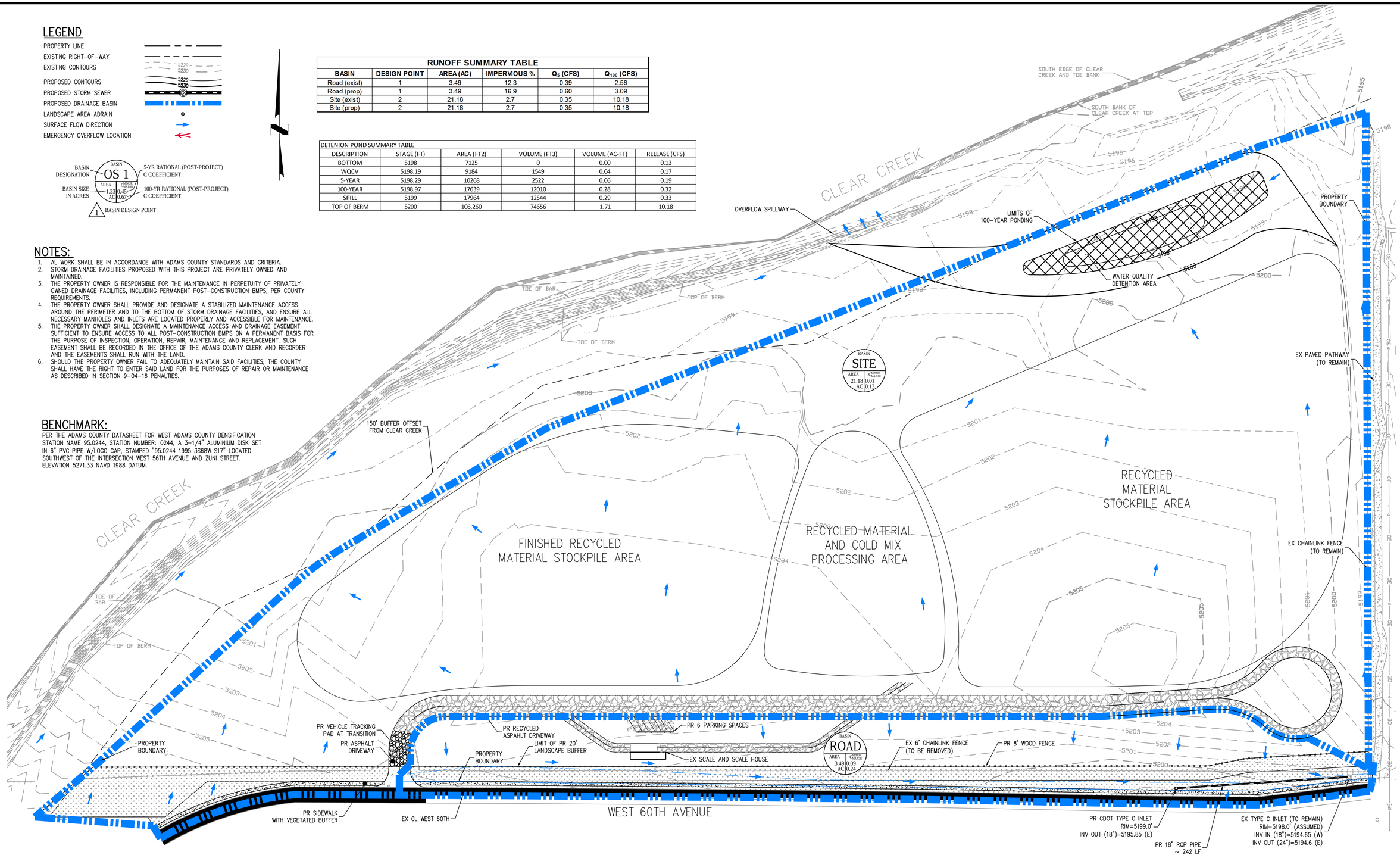
DESCRIPTION	STAGE (FT)	AREA (FT2)	VOLUME (FT3)	VOLUME (AC-FT)	RELEASE (CFS)
BOTTOM	5198	7125	0	0.00	0.13
WQCV	5198.19	9184	1549	0.04	0.17
5-YEAR	5198.29	10268	2522	0.06	0.19
100-YEAR	5198.97	17639	12010	0.28	0.32
SPILL	5199	17964	12544	0.29	0.33
TOP OF BERM	5200	106,260	74656	1.71	10.18

NOTES:

1. ALL WORK SHALL BE IN ACCORDANCE WITH ADAMS COUNTY STANDARDS AND CRITERIA.
2. STORM DRAINAGE FACILITIES PROPOSED WITH THIS PROJECT ARE PRIVATELY OWNED AND MAINTAINED.
3. THE PROPERTY OWNER IS RESPONSIBLE FOR THE MAINTENANCE IN PERPETUITY OF PRIVATELY OWNED DRAINAGE FACILITIES, INCLUDING PERMANENT POST-CONSTRUCTION BMPS, PER COUNTY REQUIREMENTS.
4. THE PROPERTY OWNER SHALL PROVIDE AND DESIGNATE A STABILIZED MAINTENANCE ACCESS AROUND THE PERIMETER AND TO THE BOTTOM OF STORM DRAINAGE FACILITIES, AND ENSURE ALL NECESSARY MANHOLES AND INLETS ARE LOCATED PROPERLY AND ACCESSIBLE FOR MAINTENANCE.
5. THE PROPERTY OWNER SHALL DESIGNATE A MAINTENANCE ACCESS AND DRAINAGE EASEMENT SUFFICIENT TO ENSURE ACCESS TO ALL POST-CONSTRUCTION BMPS ON A PERMANENT BASIS FOR THE PURPOSE OF INSPECTION, OPERATION, REPAIR, MAINTENANCE AND REPLACEMENT. SUCH EASEMENT SHALL BE RECORDED IN THE OFFICE OF THE ADAMS COUNTY CLERK AND RECORDER AND THE EASEMENTS SHALL RUN WITH THE LAND.
6. SHOULD THE PROPERTY OWNER FAIL TO ADEQUATELY MAINTAIN SAID FACILITIES, THE COUNTY SHALL HAVE THE RIGHT TO ENTER SAID LAND FOR THE PURPOSES OF REPAIR OR MAINTENANCE AS DESCRIBED IN SECTION 9-04-16 PENALTIES.

BENCHMARK:

PER THE ADAMS COUNTY DATASHEET FOR WEST ADAMS COUNTY DENSIFICATION STATION NAME 95.0244, STATION NUMBER: 0244, A 3-1/4" ALUMINIUM DISK SET IN 6" PVC PIPE W/LOGO CAP, STAMPED "95.0244 1995 3S68W S17" LOCATED SOUTHWEST OF THE INTERSECTION WEST 56TH AVENUE AND ZUNI STREET. ELEVATION 5271.33 NAVD 1988 DATUM.



60 0 60 120
SCALE: 1" = 60'

DESIGNED BY: DESIGNER
CHECKED BY: REVIEWER
DRAWN BY: DRAFTER

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BRANNAN SAND AND GRAVEL

CONDITIONAL USE PERMIT - PIT R
DRAINAGE PLAN

ISSUE DATE: 11-25-2019 | PROJECT #: 190915

DATE	REVISION COMMENTS

PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO. 4
4 OF 6

BMP LEGEND:

APPROX. LIMIT OF CONSTRUCTION AND DISTURBED AREA		LOC LOC
SILT FENCE	SF	
INLET PROTECTION	IP	
STABILIZED STAGING AREA	SSA	
VEHICLE TRACKING CONTROL	VTC	
SEDIMENT CONTROL LOG	SCL	SCL SCL
SANDY SOIL MIX	SSM	

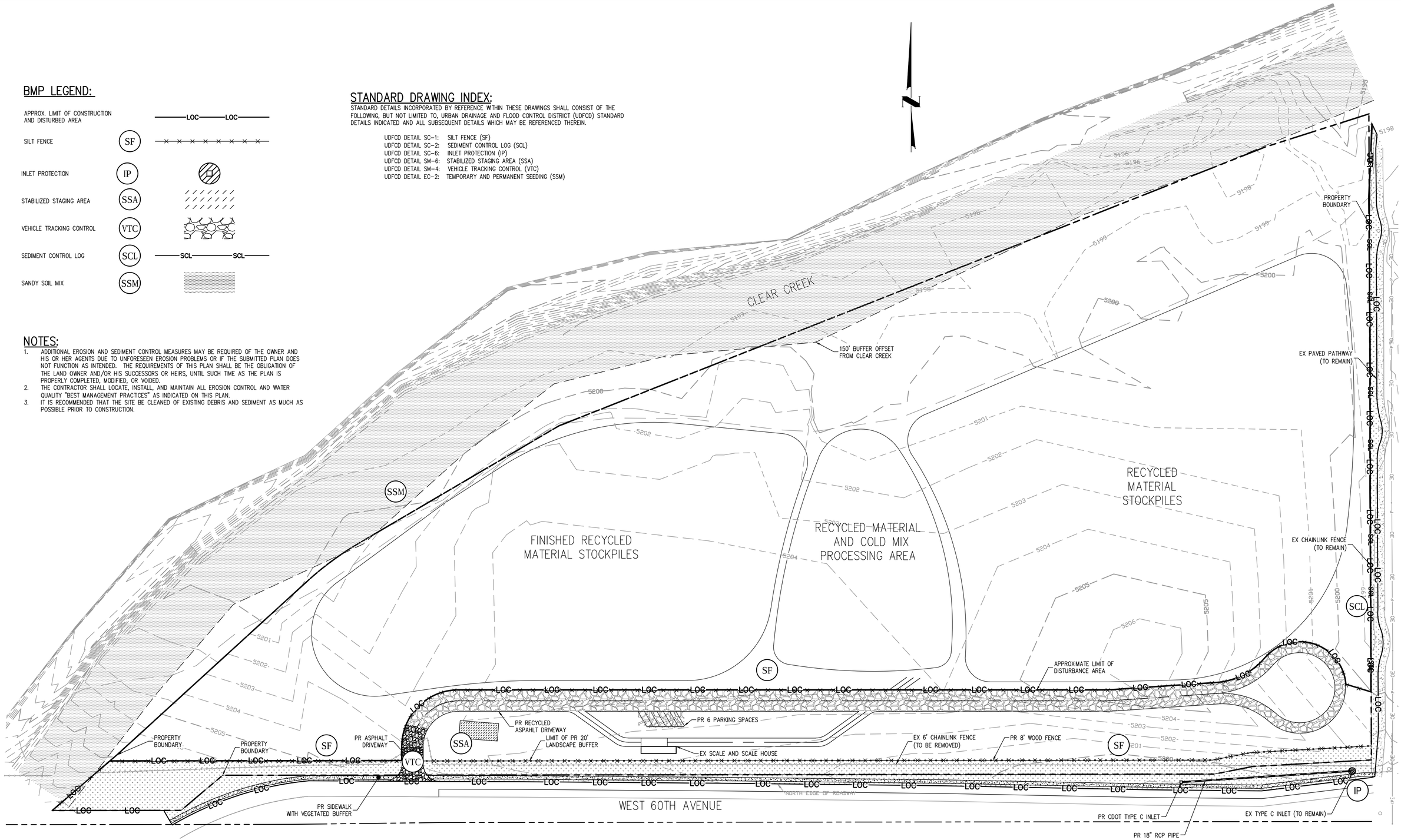
STANDARD DRAWING INDEX:

STANDARD DETAILS INCORPORATED BY REFERENCE WITHIN THESE DRAWINGS SHALL CONSIST OF THE FOLLOWING, BUT NOT LIMITED TO, URBAN DRAINAGE AND FLOOD CONTROL DISTRICT (UDFCD) STANDARD DETAILS INDICATED AND ALL SUBSEQUENT DETAILS WHICH MAY BE REFERENCED THEREIN.

UDFCD DETAIL SC-1: SILT FENCE (SF)
UDFCD DETAIL SC-2: SEDIMENT CONTROL LOG (SCL)
UDFCD DETAIL SC-6: INLET PROTECTION (IP)
UDFCD DETAIL SM-6: STABILIZED STAGING AREA (SSA)
UDFCD DETAIL SM-4: VEHICLE TRACKING CONTROL (VTC)
UDFCD DETAIL EC-2: TEMPORARY AND PERMANENT SEEDING (SSM)

NOTES:

1. ADDITIONAL EROSION AND SEDIMENT CONTROL MEASURES MAY BE REQUIRED OF THE OWNER AND HIS OR HER AGENTS DUE TO UNFORESEEN EROSION PROBLEMS OR IF THE SUBMITTED PLAN DOES NOT FUNCTION AS INTENDED. THE REQUIREMENTS OF THIS PLAN SHALL BE THE OBLIGATION OF THE LAND OWNER AND/OR HIS SUCCESSORS OR HEIRS, UNTIL SUCH TIME AS THE PLAN IS PROPERLY COMPLETED, MODIFIED, OR VOIDED.
2. THE CONTRACTOR SHALL LOCATE, INSTALL, AND MAINTAIN ALL EROSION CONTROL AND WATER QUALITY "BEST MANAGEMENT PRACTICES" AS INDICATED ON THIS PLAN.
3. IT IS RECOMMENDED THAT THE SITE BE CLEANED OF EXISTING DEBRIS AND SEDIMENT AS MUCH AS POSSIBLE PRIOR TO CONSTRUCTION.



Know what's below. Call before you dig.
CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

60 0 60 120
SCALE: 1" = 60'

DESIGNED BY: DESIGNER
CHECKED BY: REVIEWER
DRAWN BY: DRAFTER

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BRANNAN SAND AND GRAVEL

CONDITIONAL USE PERMIT - PIT R
EROSION CONTROL

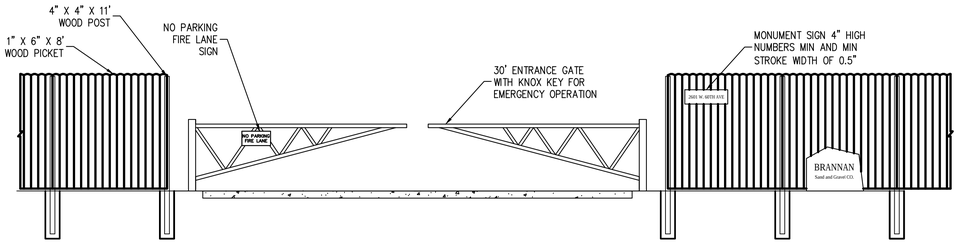
ISSUE DATE: 11-25-2019 | PROJECT #: 190915

DATE	REVISION COMMENTS

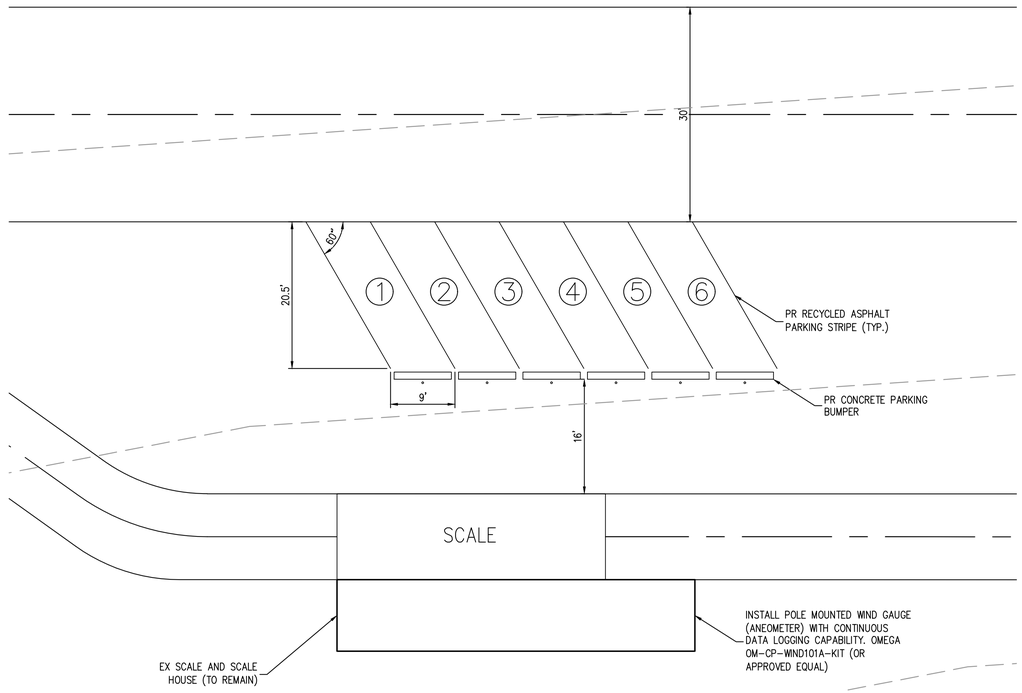
PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO. 5
5 OF 6

FILEPATH: P:\190915\ENGINEERING\EROSION\EROSION CONTROL.DWG LAYOUT: LAYOUT1
9 XREFS: 190915 drainage plan[U], c-base-xyoz, c-legal-xyoz, c-topo, c-util-xyoz, p-base, p-legal, p-storm, p-topo[U]
PLOTTED: MON 05/04/20 3:01:23P BY: MARK WEST



FENCING DETAIL
(1"=5')



PARKING PLAN
(1"=10')

811 Know what's below. Call before you dig.
CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

10 0 10 20
SCALE: 1" = 10'

DESIGNED BY: DESIGNER
CHECKED BY: REVIEWER
DRAWN BY: DRAFTER

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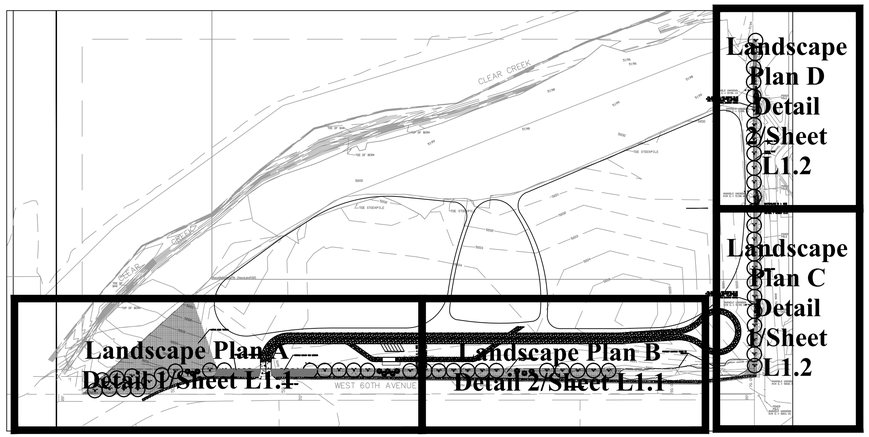
BRANNAN SAND AND GRAVEL

CONDITIONAL USE PERMIT - PIT R
PARKING PLAN

ISSUE DATE: 11-25-2019	PROJECT #: 190915
DATE	REVISION COMMENTS

PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO.
6
6 OF 6



1 OVERALL LANDSCAPE PLAN

Scale: 1"=200'

North

0 200 400 600

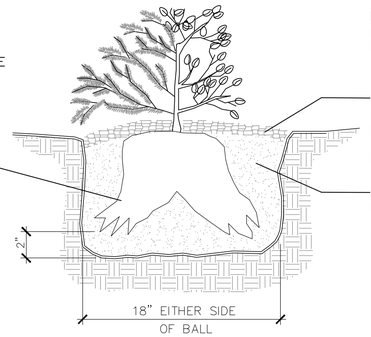
SCALE 1"=200'-0"

EVERGREEN SHRUB

PLACE SPREADING EVERGREEN SHRUBS PERPENDICULAR TO SLOPE OF GROUND. LEAVE ENOUGH SPACE UNDER BRANCHES FOR MULCH.

MOUND BACKFILL UNDER ROOTBALL.

REMOVE CONTAINER, SPLIT BOTTOM 1/2 OF BALL, SPREAD AND PLANT



DECIDUOUS SHRUB

PRUNE AS DIRECTED BY LANDSCAPE ARCHITECT.

SET SHRUB PLUMB.

MULCH OVER MOUNDED BACKFILL. BUILD A 4" BERM AROUND SHRUB TO CREATE A WATERING BASIN IN NON-IRRIGATED AREAS ONLY.

PREPARED BACKFILL MIXTURE:
1. TWO PARTS NATIVE SOIL FROM PIT EXCAVATION.
2. ONE PART BIO COMP BY A-1 ORGANICS PER SPEC SECTION 32 91 13.
3. MATERIALS TO BE THOROUGHLY BLENDED.

NOTE: ALL PLANTS ARE TO BE NURSERY GROWN STOCK FROM GROWERS LOCATED IN USDA HARDINESS ZONES 1,2,3 OR 4.

2 SHRUB PLANTING DETAIL

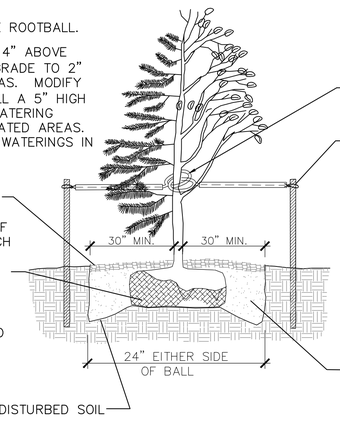
NOT TO SCALE

DIG HOLE TWO TIMES THE SIZE OF THE ROOTBALL.

NOTE: SET ROOT BALL OF ALL TREES 4" ABOVE GRADE IN IRRIGATED AREAS AND AT GRADE TO 2" ABOVE GRADE IN NON-IRRIGATED AREAS. MODIFY IF SOIL CONDITIONS WARRANT. INSTALL A 5" HIGH BERM AROUND TREES TO CREATE A WATERING BASIN. BERM IS TEMPORARY IN IRRIGATED AREAS. REMOVE BERM AFTER TWO THOROUGH WATERINGS IN IRRIGATED AREAS AND MULCH

MULCH FLUSH WITH SOD AT EDGE. PROVIDE 30" MIN. RING FROM EDGE OF BARK TO EDGE OF MULCH

REMOVE BOTTOM 1/3 OF WIRE BASKET. SET TREE IN PIT TO PROPER GRADE AND PLUMB. REMOVE REMAINING WIRE AND TWINE. IF PLASTIC OR TREATED BURLAP, REMOVE AS MUCH AS POSSIBLE AND BACKFILL. IF REGULAR BURLAP, BACKFILL 2/3 OF PIT. REMOVE 1/3 OF BURLAP AND COMPLETE BACKFILL.



DIG HOLE TWO TIMES THE SIZE OF THE ROOTBALL.

PRUNE AS DIRECTED BY OWNER'S REPRESENTATIVE. DO NOT PRUNE OR DAMAGE CENTRAL LEADER.

WRAP TRUNK FROM GROUND LEVEL TO SECOND BRANCH WITH 4 INCH KRAFT TYPE TREE WRAP. SECURE ENDS WITH FLEXIBLE TAPE.

GUYING SYSTEM:
MIN. 6 FEET LONG HEAVY DUTY WOOD POST STAKES WITH 12 GAUGE GALVANIZED STEEL WIRE GUYS SECURED TO TREE WITH 1" CANVAS STRAP ABOVE FIRST BRANCH. WIRE TO BE TAUT BUT NOT OVER TIGHT. FLAG WIRE WITH 1/2" WHITE PVC PLASTIC PIPE.

CONIFERS TO HAVE 2 STAKES FOR TREES 6 FEET AND LESS. 3 STAKES FOR TREES ABOVE 6 FEET. DECIDUOUS TREES TO HAVE 2 STAKES FOR TREES 2-1/2" CAL. ONE STAKE ALWAYS IN DIRECTION OF PREVAILING WINDS. REMOVE STAKES & GUYS AFTER 1 YEAR.

PREPARED BACKFILL MIXTURE:
1. TWO PARTS NATIVE SOIL FROM PIT EXCAVATION.
2. ONE PART BIO COMP BY A-1 ORGANICS PER SPEC SECTION 32 91 13.
3. MATERIALS TO BE THOROUGHLY BLENDED.

NOTE: ALL PLANTS ARE TO BE NURSERY GROWN STOCK FROM GROWERS LOCATED IN USDA HARDINESS ZONES 1,2,3 OR 4.

3 TREE PLANTING DETAIL

NOT TO SCALE

LEGEND

- DECIDUOUS SHADE TREE
- EVERGREEN TREE
- ORNAMENTAL TREE
- DECIDUOUS SHRUB
- 4"-24" BRANNAN SAND AND GRAVEL NATURAL COLORED RIVER ROCK MULCH OVER GEOTEXTILE FABRIC
- LOW GROW NATIVE SEED MIX, ARKANSAS VALLEY LOW GROW SEED MIX, AMEND SOIL FOR SEED WITH 3 CY OF A1 ORGANICS SOIL AMENDMENT PER 1,000 SF TILLED IN TO 9" DEPTH. APPLY SEED AT A RATE OF 25 LBS PER ACRE. CONTRACTOR RESPONSIBLE FOR PROVIDING WATER AS REQUIRED UNTIL SEED IS ESTABLISHED.

PLANT SCHEDULE

SYMBOL	Botanical Name / COMMON NAME	SIZE
	DECIDUOUS TREES:	
GL TR	Gleditsia triacanthos inermis 'Shademaster' SHADEMASTER HONEYLOCUST	2 1/2" B&B
CE OC	Celtis occidentalis WESTERN HACKBERRY	2 1/2" B&B
QU RU	Quercus rubra RED OAK	2 1/2" B&B
PO AN	Populus angustifolia NARROWLEAF COTTONWOOD	2 1/2" B&B
	EVERGREEN TREES:	
JU MO	Juniperus monosperma ONE SEED JUNIPER	6' B&B
	ORNAMENTAL TREES	
AC GR	Acer grandidentatum BIGTOOTH MAPLE	1 1/2" B&B
	DECIDUOUS SHRUBS:	
RH AR	Rhus aromatica 'Grow Low' GROW LOW FRAGRANT SUMAC	#5 Cont.
PR PA	Prunus besseyi 'Pawnee Buttes' CREEPING WESTERN SAND CHERRY	#5 Cont.

GENERAL NOTES:

1. THE CONTRACTOR SHALL BE SOLELY RESPONSIBLE FOR SAFETY IN, ON OR ABOUT THE PROJECT SITE. ANY DAMAGE TO ADJACENT PROPERTY OR UTILITIES, NOT DESIGNATED FOR REMOVAL, RELOCATION OR REPLACEMENT, SHALL BE REPAIRED AND/OR REPLACED BY THE CONTRACTOR AT THE CONTRACTOR'S EXPENSE.
2. THE CONTRACTOR SHALL BE RESPONSIBLE FOR OBTAINING ANY PERMITS OR LICENSES REQUIRED FOR THE PERFORMANCE OF THE WORK AS APPLICABLE TO THE PROJECT.
3. THE LANDSCAPE ARCHITECT AND/OR OWNER MAKE NO WARRANTY AS TO THE CORRECTNESS AND/OR COMPLETENESS OF THE EXISTING FEATURES SHOWN OR NOT SHOWN ON THE PLANS. THE CONTRACTOR SHALL BE RESPONSIBLE FOR FIELD VERIFYING THE HORIZONTAL AND VERTICAL LOCATION OF ALL EXISTING UTILITIES INCLUDING WATER, SEWER, STORM DRAINS, GAS TRANSMISSION LINES, AND OTHER UTILITIES ABOVE AND BELOW THE SURFACE THAT MAY AFFECT THE PROJECT. SHOULD DISCREPANCY OR CONFLICT BE DISCOVERED THE CONTRACTOR SHALL NOTIFY THE OWNER IMMEDIATELY, AND SHALL NOT CONTINUE CONSTRUCTION UNTIL SAID CONFLICT CAN BE RESOLVED IN WRITING.
4. THE CONTRACTOR SHALL NOTIFY ALL UTILITY COMPANIES AT LEAST 48 HOURS PRIOR TO BEGINNING CONSTRUCTION TO VERIFY DEPTH AND LOCATION OF ALL UTILITIES.
5. ANY CONSTRUCTION DEBRIS OR MUD-TRACKING IN THE PUBLIC RIGHT-OF-WAY RESULTING FROM THE WORK SHALL BE REMOVED IMMEDIATELY BY THE CONTRACTOR.
6. THE CONTRACTOR SHALL PROVIDE ALL LIGHTS, SIGNS, BARRICADES, FLAGMEN AND OTHER DEVICES NECESSARY TO PROVIDE FOR THE PUBLIC SAFETY ON AND ABOUT THE SITE. THE CONTRACTOR SHALL FURNISH APPROPRIATE TRAFFIC CONTROL AND SAFETY MEASURES IN ACCORDANCE WITH AURORA PUBLIC SCHOOLS REQUIREMENTS.
7. CONTRACTOR SHALL TAKE APPROPRIATE MEASURES TO PROTECT BOTH ON SITE AND ADJACENT PROPERTY. AREAS OUTSIDE THE LIMITS OF WORK AS SHOWN ON THE PLANS SHALL REMAIN UNDISTURBED. ANY ITEMS NOT INTENDED FOR DEMOLITION MUST BE PROTECTED. ANY DAMAGE WILL BE REPAIRED AT CONTRACTOR'S EXPENSE.
8. CONTRACTOR SHALL REMOVE ALL DEBRIS FROM DEMOLITION OPERATIONS ON A DAILY BASIS.
9. THE CONTRACTOR SHALL BE RESPONSIBLE FOR ALL CONSTRUCTION SURVEYING. LAYOUT AND STAKING OF ALL IMPROVEMENTS SHALL BE APPROVED BY THE OWNER PRIOR TO INSTALLATION OF IMPROVEMENTS. DISCREPANCIES TO THE BASE INFORMATION SHALL BE BROUGHT TO THE PROJECT MANAGER'S ATTENTION FOR A DECISION PRIOR TO COMMENCING WITH THE WORK. NOTIFICATION OF REQUEST FOR FIELD REVIEW SHALL BE MADE A MINIMUM OF 24 HOURS IN ADVANCE.
10. CONTRACTOR SHALL BE RESPONSIBLE FOR NOTIFYING THE PROJECT MANAGER IF ANY SIGNIFICANT INCONSISTENCIES BETWEEN THE EXISTING CONDITIONS AND THESE PLANS ARE DISCOVERED.
11. ALL CONSTRUCTION SHALL CONFORM WITH THE APPLICABLE STANDARDS AND SPECIFICATIONS OF ADAMS COUNTY.
12. THE APPLICANT AGREES TO MAINTAIN PLANTINGS AND OTHER PROPOSED LANDSCAPE IMPROVEMENTS SHOWN ON THIS PLAN WITHOUT REGARD TO LOCATION INSIDE OR OUTSIDE PUBLIC RIGHT-OF-WAY. TO THE EXTENT THAT PLANTINGS ULTIMATELY RESIDE IN THE PUBLIC RIGHT-OF-WAY, THE APPLICANT AGREES TO INCORPORATE MAINTENANCE INTO A DEVELOPMENT AGREEMENT OR OTHER APPROPRIATE INSTRUMENT AT ADAMS COUNTY'S DISCRETION.
13. THE APPLICANT AGREES TO ESTABLISH AND MAINTAIN VEGETATION THROUGH HAND-WATERING, DELIVERED BY THE APPLICANT'S WATER TRUCK.

SUMMARY OF ADAMS COUNTY LANDSCAPE REQUIREMENTS

4-16-07 REQUIRED LOT LANDSCAPING
TOTAL LOT AREA: 1,019,598 S.F.
MINIMUM LANDSCAPE AREA 10% OF THE LOT AREA: 101,959 S.F. LANDSCAPING PROVIDED: 102,110 S.F.

4-16-07-01 STREET FRONTAGE LANDSCAPING
ALONG WEST 60TH AVENUE: 1900 L.F
TREES REQUIRED: 48, PROVIDED: 48
SHRUBS REQUIRED: 96 PROVIDED : 96
ALONG PUBLIC TRAIL TO EAST 921 L.F.
TREES REQUIRED: 23, PROVIDED: 23
SHRUBS REQUIRED: 46, PROVIDED: 46

PRELIMINARY FOR ILLUSTRATIVE PURPOSES ONLY

811 Know what's below. Call before you dig.

CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

DESIGNED BY: KJM
CHECKED BY: KJM
DRAWN BY: KJM

HKS HARRIS KOCHER SMITH
1120 Lincoln Street, Suite 1000
Denver, Colorado 80203
P: 303.623.6300 F: 303.623.6311
HarrisKocherSmith.com

BRANNAN SAND AND GRAVEL COMPANY, LLC

PIT-R CONDITIONAL USE PERMIT
LANDSCAPE NOTES, DETAILS AND LEGEND

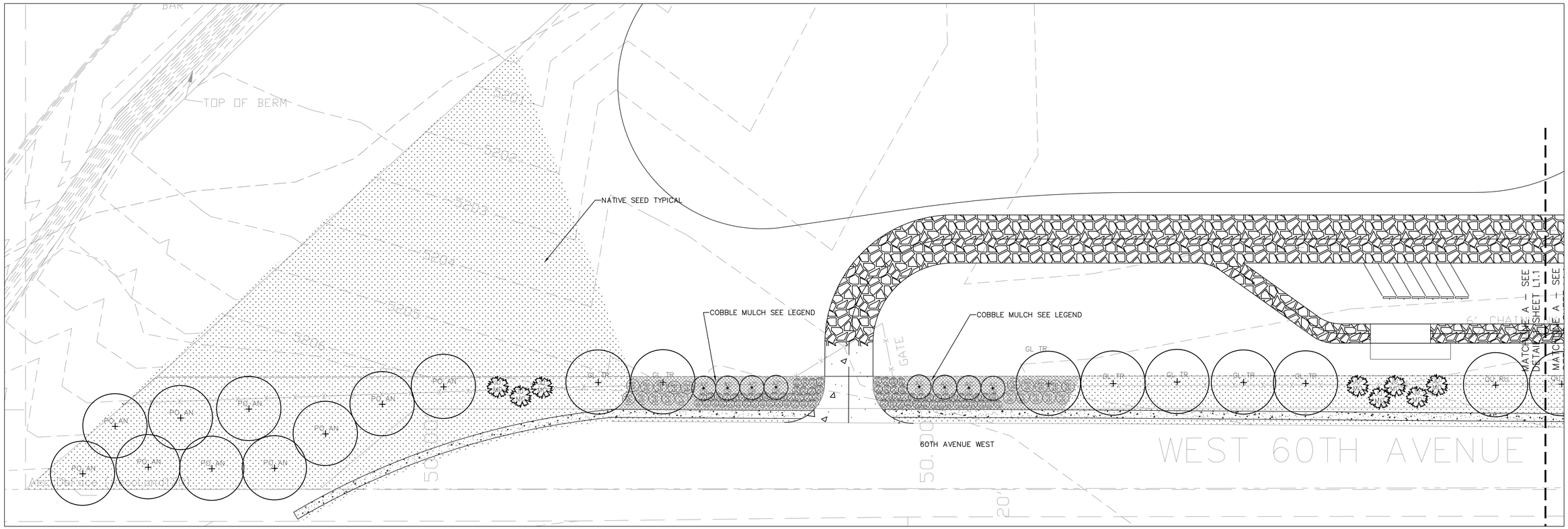
ISSUE DATE: 11/25/19 PROJECT #: 190915

DATE	REVISION COMMENTS
####	####
####	####
####	####
####	####
####	####
####	####
####	####

PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO.
L1.0
01 OF 03

FILEPATH: C:\DATA\2019 PROJECTS\2019-31 BRANNAN PIT R\DRAWINGS\2019-31 BRANNAN PIT R LANDSCAPE PLAN.DWG LAYOUT: L1.0
PLOTTED: TUE 11/26/19 2:45:38P BY: KURT

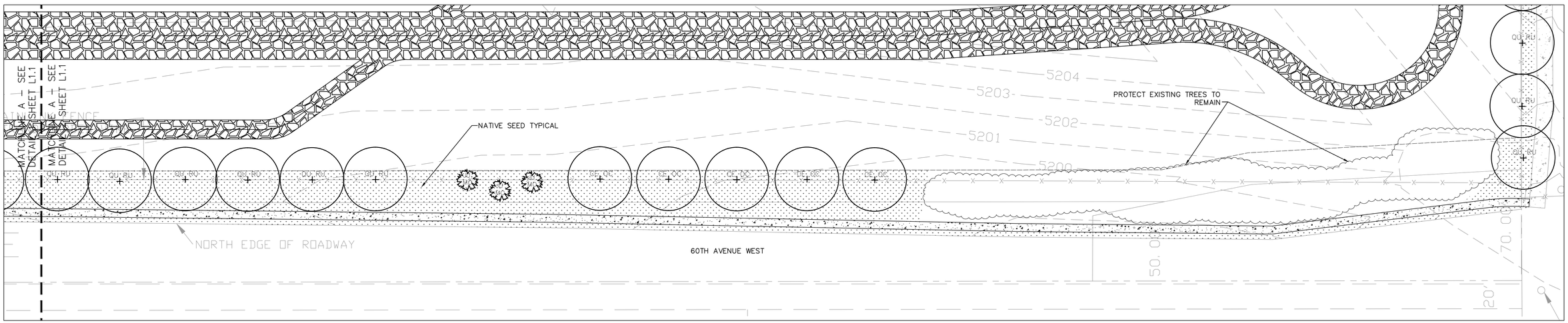


1 LANDSCAPE PLAN -A- ENLARGEMENT

Scale: 1"=30'

0 30 60 90

SCALE 1"=30'-0"



2 LANDSCAPE PLAN -B- ENLARGEMENT

Scale: 1"=30'

0 30 60 90

SCALE 1"=30'-0"

PRELIMINARY FOR ILLUSTRATIVE PURPOSES ONLY

811 Know what's below. Call before you dig.

CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

DESIGNED BY: KJM
CHECKED BY: KJM
DRAWN BY: KJM

HARRIS KOCHER SMITH
1120 Lincoln Street, Suite 1000
Denver, Colorado 80203
P: 303.623.6300 F: 303.623.6311
HarrisKocherSmith.com

BRANNAN SAND AND GRAVEL COMPANY, LLC

PIT-R CONDITIONAL USE PERMIT
LANDSCAPE PLAN ENLARGEMENTS

ISSUE DATE: 11/25/19 PROJECT #: 190915

DATE	REVISION COMMENTS
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PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO.
L1.1
02 OF 03

FILEPATH: C:\DATA\2019 PROJECTS\2019-31 BRANNAN PIT R\DRAWINGS\2019-31 BRANNAN PIT R LANDSCAPE PLAN.DWG LAYOUT: L1.1
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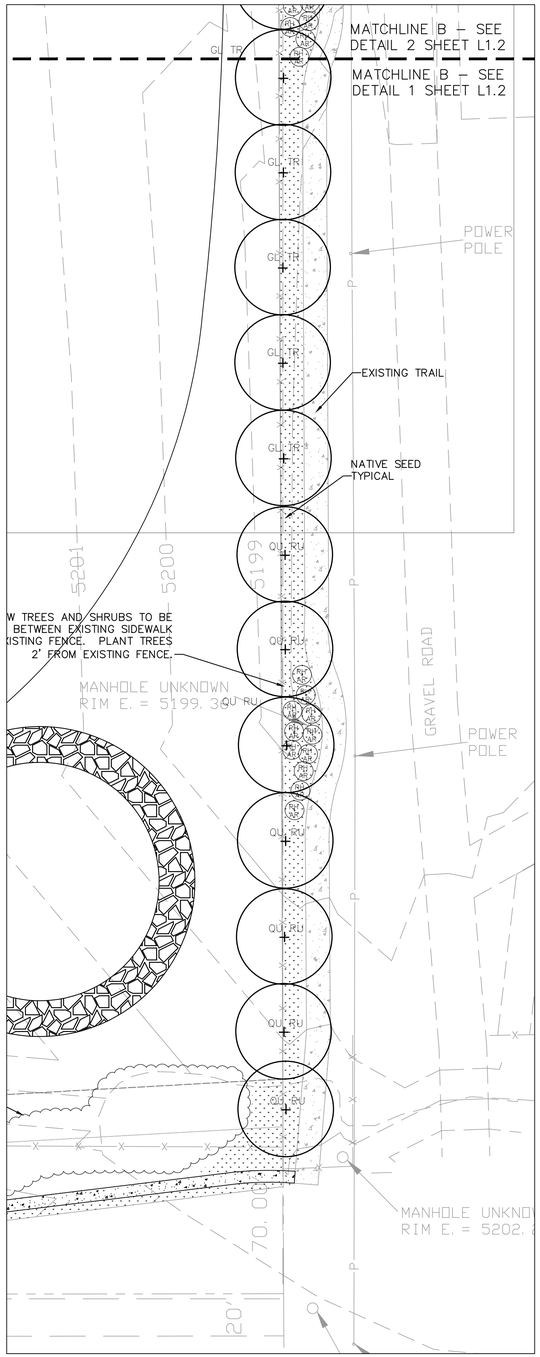
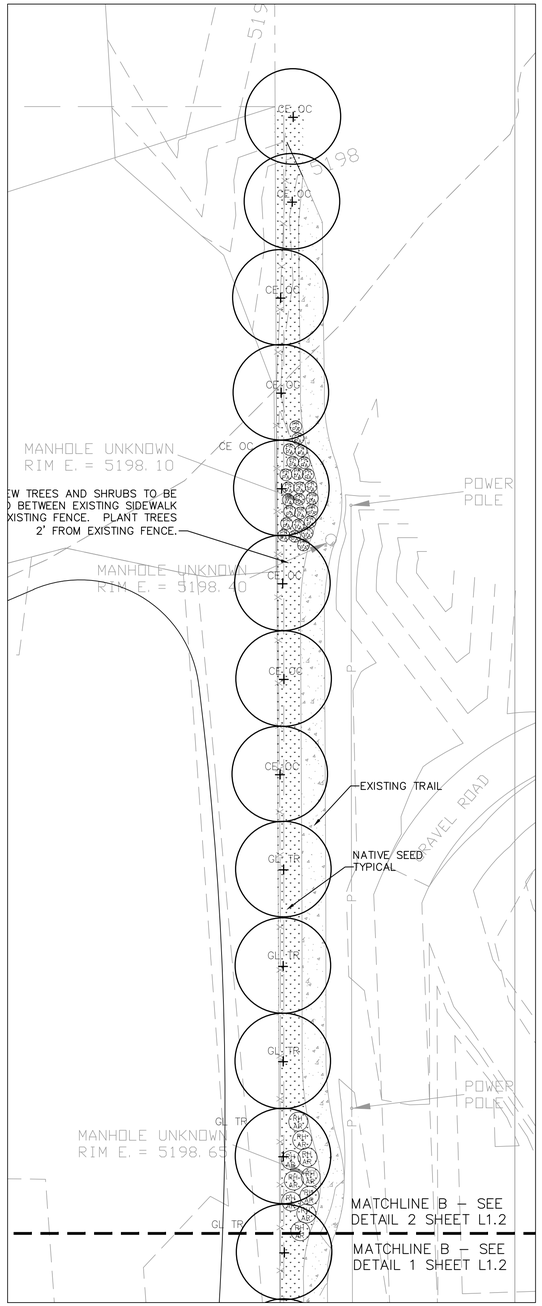


1 LANDSCAPE PLAN -C- ENLARGEMENT

Scale: 1"=30'

North 0 30 60 90

SCALE 1"=30'–0"



2 LANDSCAPE PLAN -D- ENLARGEMENT

Scale: 1"=30'

North 0 30 60 90

SCALE 1"=30'–0"

PRELIMINARY FOR ILLUSTRATIVE PURPOSES ONLY

811 Know what's below. Call before you dig.

CALL 3 BUSINESS DAYS IN ADVANCE BEFORE YOU DIG, GRADE, OR EXCAVATE FOR THE MARKING OF UNDERGROUND MEMBER UTILITIES.

DESIGNED BY: KJM
CHECKED BY: KJM
DRAWN BY: KJM

HARRIS KOCHER SMITH
1120 Lincoln Street, Suite 1000
Denver, Colorado 80203
P: 303.623.6300 F: 303.623.6311
HarrisKocherSmith.com

BRANNAN SAND AND GRAVEL COMPANY, LLC

PIT-R CONDITIONAL USE PERMIT
LANDSCAPE PLAN ENLARGEMENTS

ISSUE DATE: 11/25/19 PROJECT #: 190915

DATE	REVISION COMMENTS
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PRELIMINARY NOT FOR CONSTRUCTION

SHEET NO. L1.2

03 OF 03

FILEPATH: C:\DATA\2019 PROJECTS\2019-31 BRANNAN PIT R\DRAWINGS\2019-31 BRANNAN PIT R LANDSCAPE PLAN.DWG LAYOUT: L1.2
PLOTTED: TUE 11/26/19 2:46:08P BY: KURT

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, CO 80601-8204
PHONE 720.523.6800
FAX 720.523.6998

Development Review Team Comments

Date: 6/8/2020

Project Number: PRC2019-00020

Project Name: Brannan Sand & Gravel (Pit R)

Commenting Division: Planner Review 2nd Review

Name of Reviewer: Greg Barnes

Date: 06/08/2020

Email: gjbarnes@adcogov.org

Complete

PLN01: Landscape plans were submitted with the original application, but no landscape plan was submitted with the resubmittal package. Even with the addition of landscaping, it is unlikely that this use will be appropriate for the area, based on Criterion #4 regarding compatibility. The best path forward may be scheduling the case for public hearing.

Commenting Division: Development Engineering Review 2nd Review

Name of Reviewer: Greg Labrie

Date: 05/22/2020

Email: glabrie@adcogov.org

Complete

ENG1: The applicant will be required to complete and submit the Adams County construction permit application (INF) along with the supporting engineering documents for the proposed site improvements and right-of-way improvements. The construction permit must be reviewed and approved by Development Engineering before construction can begin.

Commenting Division: Environmental Analyst Review 2nd Review

Name of Reviewer: Katie Keefe

Date: 05/21/2020

Email:

Complete

The following are a list of potential conditions, if approved:
The applicant shall install a wind gauge, such as an anemometer, in the vicinity of crushing operations to monitor wind speeds and shall cease dust generating activities when wind speeds exceed a sustained 25 mph or gusts exceed 35 mph. Records of operation shutdown due to high winds shall be maintained and made available to Adams County upon request.

Fugitive dust control measures as prescribed within the facility's Air Pollutant Emission Notice permit as issued by CDPHE, must be in place and functioning at all times. There must be no off-property transport of visible emissions nor shall visible dust emissions exceed 20% opacity.

The applicant shall install sediment control BMPs along the site access and use a sweeper as frequently as necessary to prevent tracking and offsite transport of mud and dirt from the facility onto the public right of way.

The applicant has agreed as a condition of the permit to conduct semi-annual noise monitoring and airborne dust monitoring while crushing and recycling operations are active. Noise and air monitoring results shall be provided to the Director of Community and Economic Development within seven days of receiving monitoring results.

Aboveground petroleum storage tanks used for equipment fueling must be placed within secondary containment and meet applicable fire code requirements.

If fuel will be stored on this site:
- All fuel storage at this site shall be provided with secondary containment, which complies with State of Colorado Oil Inspection Section Regulations; and
- Fueling areas shall be separated from the rest of the site's surface area, and protected from storm water; and
- Applicant shall make available for review by the County its Spill Prevention, Control, and Countermeasures Plan.

All fluid spills such as hydraulic and oil from maintenance of equipment, shall be removed and disposed of at a facility permitted for such disposal.

Planner Comments

Case Manager: Greg Barnes

PLN01: There are three applications being submitted: Conditional use permit to allow recycling operations in the I-2 and I-3 zone districts, conditional use permit to allow accessory outdoor storage in the I-2 and I-3 zone districts, and conditional use permit to allow stacking of material over the height of fencing.

PLN02: The subject property is located within a future land use designation as "Activity Center". This designation is intended for a future land use that will accommodate a very high intensity office, residential, and commercial uses. These areas shall provide allowances for pedestrian and bicycle transportation that will promote transit uses. The proposal of recycling operations and outdoor storage is inconsistent with the County's Comprehensive Plan.

PLN03: The area is nearby a commuter rail station and the proposal may have substantial impacts on the future development of the surrounding area. Recycling operations may create off-site impacts that may also be detrimental to the surrounding neighborhood and its future development.

PLN04: Although staff may be unlikely to support this use, the chances for approval by the Board of County Commissioners will be increased if off-site impacts are strongly mitigated. We can brainstorm at the upcoming RCC on how the application can be enhanced.

PLN05: Please provide an elevation drawing of the proposed 8' wood fence.

PLN06: At the upcoming RCC, there should be further discussion of vehicle tracking onto public roadways and overall truck traffic volumes.

PLN07: It is recommended that staff and the applicant continue to assess a reduction of the proposed height of materials.

PRC2019-00020; Brannan Sand & Gravel Pit R
Request: CUP's for recycling operations, outdoor storage, and over fence height stacking of material.
Address: 2601 W 60th Avenue
CLU/FLU: I-2/ Activity Center
Plans:

SW Area Framework Plan

- Policy 14.1 Promote Clean Industrial Uses; Encourage development and redevelopment of a range of industrial uses in the Southwest Area, with particular emphasis on new clean and/ or light industrial uses.

Balanced Housing Plan- N/A

Clear Creek Valley TOD Plan (see attached maps)

Goal – Clear Creek at Federal Station

The vision for the Clear Creek at Federal Station is to create a new, vibrant, transit-oriented community amenity within walking distance of the transit station. New retail, employment, entertainment and living opportunities within the new Village Center will serve the needs of the existing community and maintain the area as an employment center for Adams County.

Station Area Goals:

Maintain and enhance existing commercial corridors

Create new connections with surrounding residential and commercial areas Revitalize older commercial and industrial areas

Encourage mixed use development

Promote sustainable development

Enhance area's role as a gateway to Southwest Adams County

Maintain and enhance existing residential neighborhoods

Improve open space and recreational opportunities

Revitalize vacant and underutilized land

TOD and Rail Station Area Planning Guidelines

- Policy: Ensure that development patterns are compatible with both the established character of the county and the new framework provided in Station Area Plans.
    - S4. The County will discourage land use patterns in transit corridors and around transit stations that may preclude future Transit Oriented Development.
- Policy: Development intensity and density should be significantly higher in Station Areas to provide a base for a variety of housing, employment, local services and amenities that promote transit usage, encourage pedestrian activity and support a vibrant station area community.
    - #7 Discourage low-intensity, land consumptive uses related to agriculture or heavy industry such as outdoor storage or construction staging.

Federal Blvd Framework Plan

8. Corridor Planning should address potential Federal Boulevard blight conditions and recommend improvements in visual character. The addition of pedestrian-oriented improvement to the Right-of-Way is critical in providing better accommodations for non-motorized corridor transportation. Additionally, streetscape planting should be incorporated throughout the corridor with a focus on shade trees along the east and west sides of the roadway due to the utility limitations of the center medians.
10. Corridor planning should address potential methods to land assembly for redevelopment, protection of residential neighborhoods from commercial land use and traffic encroachment, and methods to interconnect the local street grid.

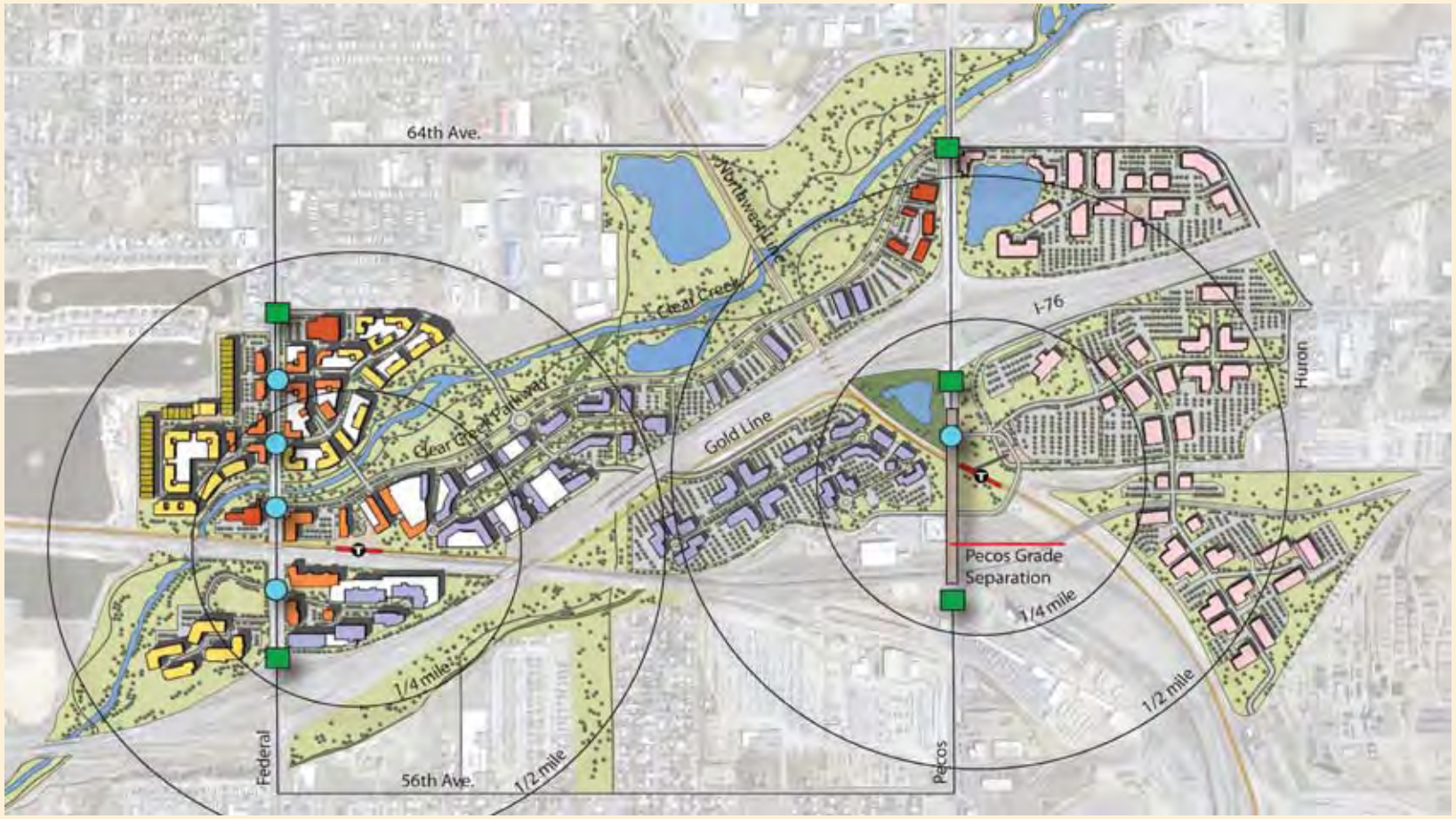
Imagine Adams Comp Plan

Activity Center- This land use category is characterized by its high intensity, mixed-use character, and high quality. The primary uses will be offices, hotels, retail, high-density residential and clean, indoor manufacturing and warehousing. Activity Centers are designated for areas that will have excellent transportation access and visibility, particularly along the FasTracks corridors. Development in Activity Centers must contain a sufficient intensity and mix of uses to create a pedestrian environment and support transit service. These centers may be especially suitable for providing a variety of housing or should be planned with due consideration of accessibility between residences and places of employment.

Making Connections

- Triangle of Opportunity. Opportunities include transit-oriented development, trail-oriented development, mixed-use development.
- 4.1 Sidewalk Program 2. Missing Sidewalk links

Option 1 - Clear Creek Parkway



Retail
Mixed use
Multi family residential
Single family attached
Business/office
Industrial
Structured parking
Signalized intersection (needs CDOT approval)
Gateway

Option 1 - Clear Creek Parkway

Approach
An approach was used that integrated the two station areas as one unified place by completing the connection of 60th Avenue from Federal Boulevard under I-76 to Pecos Street and the Pecos Junction Station. This collector road creates a new east-west connection and provides access to the Clear Creek amenity to neighborhoods and businesses south of I-76 and the rail lines. The plan is based on a future scenario of the densification that is possible after the arrival of commuter rail and opportunities for retail and residential development become a reality in the market. It has a 12-20 year planning horizon.

Overview of Option 1 - Clear Creek Parkway
Option 1 - Clear Creek Parkway is based on building a parkway north of I-76 that connects Federal Boulevard to Pecos Street along the Clear Creek amenity. The parkway expands the open space associated with the amenity and also serves to mitigate the floodplain issues in the area and enables development to occur between I-76 and and the parkway. A collector road is also proposed from 62nd Avenue and Federal Boulevard east to the Pecos Station creating a second connection between the two station areas.

Parking
In the short term, surface parking will prevail at both stations. However, as the market allows and densification occurs, mixed-use structured parking with wrapped retail on the street level is recommended. The plan shows a future vision of structured parking around the Federal Station area. Future public parking will not be paid for by RTD or Adams County. In the Gold Line EIS, RTD has bugeted for surface parking through 2030.

Circulation
Both vehicular and pedestrian circulation was a primary consideration in the plan. Access east and west has been increased, and a greatly expanded network of sidewalks and trails is integral to the concept. Pedestrian priority streets will dominate in the Village Center area and all roads in the station areas will provide for bike and pedestrian circulation.

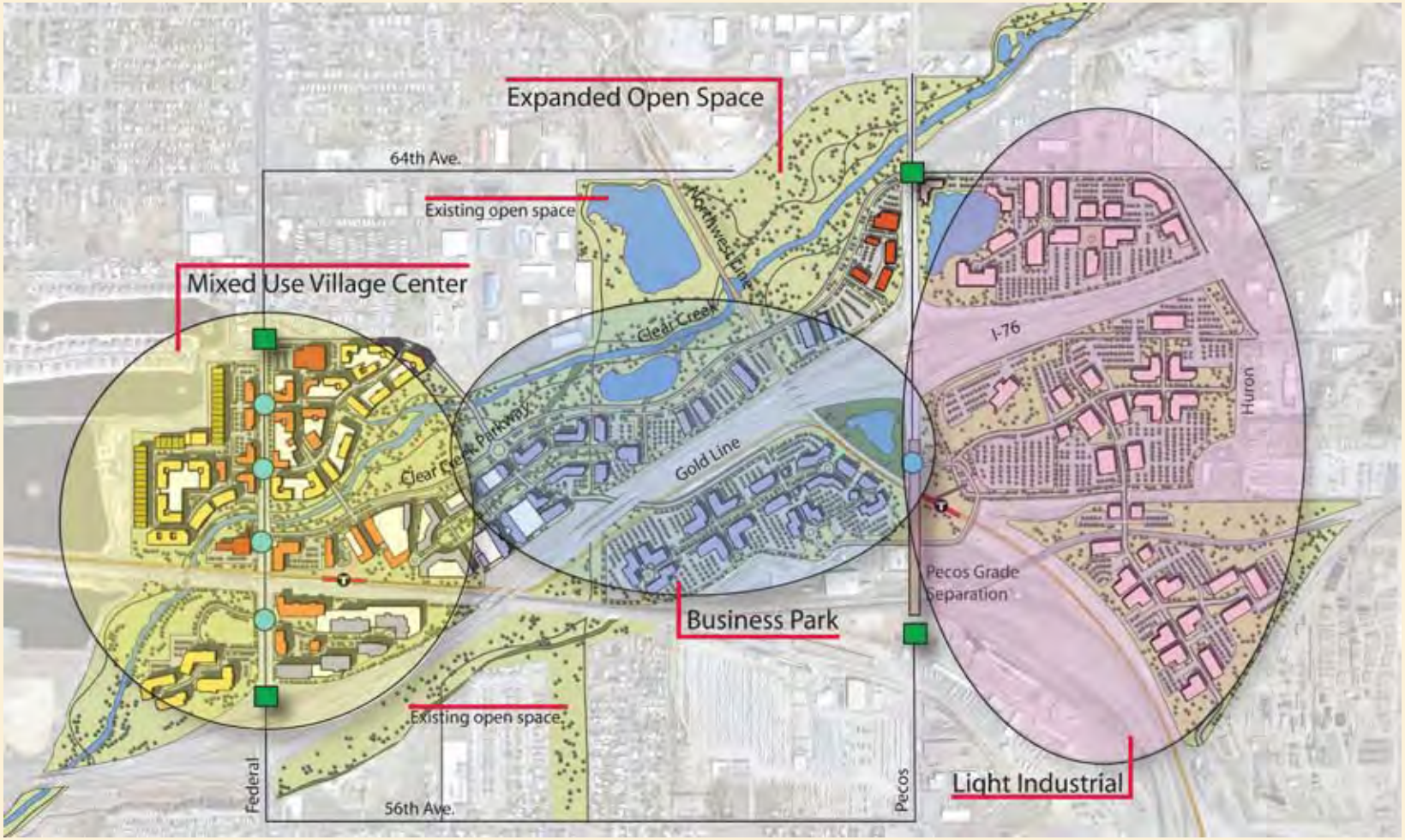
Gateways
Four gateways are noted on the plan. Whether they announce the station areas or the name of a business park, gateways become familiar landmarks that contribute to a greater sense of place and unite the various elements of the plan. Specific gateway design and area branding will need to be developed as part of an overall station identity program.


Gateway as a small median


Gateway as an overhead sign


Gateway as a corner monument

Option 1 - Clear Creek Parkway



- Retail
- Mixed use
- Multi family residential
- Single family attached
- Business/office
- Industrial
- Structured parking
- Signalized intersection (needs CDOT approval)
- Gateway

Greg Barnes

From: Gordon Stevens
Sent: Thursday, December 26, 2019 10:01 AM
To: Greg Barnes
Cc: David Rausch; Juliana J. Archuleta; Russell Nelson; Monica Lovato-Ramirez; John Dyer
Subject: RE: For Review: Brannan Sand & Gravel Pit R (PRC2019-00020)
Attachments: DOCS-#6018167-v1-SUBMITTAL__BRANNAN_SAND_AND_GRAVEL__PIT_R__2601_W__60TH_AVE___GREG_BARNES_REQUEST_FOR_COMMENT.PDF

Good Morning Mr. Barnes,

Good Morning Greg,

Thank you for the opportunity to review this submittal. The Adams County Dept. of Public Works, Infrastructure Management, Construction Inspection Division offers the following comments:

1.) Roadway Construction will be required along this frontage of this property. The roadway must be constructed to it's ultimate width along this property frontage.
2.) Construction plans must be submitted to and approved by the Community and Economic Development Department prior to beginning this construction.
3.) Although the Platting has been completed for this site, an SIA will be required along with the appropriate collateral prior to the issuance of the Conditional Use Permit.
4.) This SIA and the submitted collateral must be approved by the Board of County Commissioners prior to beginning construction.
5.) A construction Permit must be issued prior to the work commencing.
6.) The roadway along this property frontage has been substantially deteriorating along this property frontage for several years, partially due to the traffic related to this site. These construction plans must reflect the repair of this roadway in it's entirety along this property frontage.
7.) There are several drainage related issues along the property frontage of this site. These drainage issues must also be addressed as part of the aforementioned construction plans.
8.) It does not appear as though the on-site drainage issues have been addressed with this site.
9.) No building Permit will be issued for any lot until all of the Public Improvements have been completed and have received Preliminary Acceptance from the Adams County Department of Public Works.
10.) A Pre-Construction Meeting will be held with the Construction Staff of the Dept. of Public Works, prior to construction beginning.

These plans will need to be resubmitted when they are complete.

Again, thank you for this opportunity to review this submittal.

Gordon Stevens
Construction Inspection Supervisor,
Department of Public Works
Infrastructure Management Division
ADAMS COUNTY, COLORADO
4430 So, Adams County Parkway,
1st Floor, Suite W2000B

Juliana Archuleta

To: Greg Barnes
Subject: FW: For Review: Brannan Sand & Gravel Pit R (PRC2019-00020) - Stormwater

I would like to add a few request as this is a site with historic issues:
Adams County Stormwater Division recommends the following:

1) Water quality must be provided to these operations due to the proximity to Clear Creek and the pollutants on-site (recycling concrete, oils from shingles, trash, vehicle leaks, etc)
2) A drainage report needs to be submitted showing water quality design for approval. Include assessment of soil compaction and stock piles material impacts on impervious areas and coefficients. Include drainage impacts of the proposed site driveway. Provide analysis for the existing berm installed around the property to avoid outfall to Clear creek. Provide berm height, material, and alignment, capacity and construction details. Review levee designations and regulations regarding the berm. Perform an inspection of the berm, provide pictures and video. Survey the berm by a professional surveyor to ensure the existing berm matches the design. Provide engineering calculations showing that the containment berm is adequate for containing all rain events and allowing them to infiltrate into the ground within 72 hours according to CRS 37-92-602(8). List applicable permits that will be triggered.
3) If, as a result of the drainage report, a storm outlet (pipe or channel) needs to be installed at this property, then contact CDPHE's Stormwater Industrial Permit and submit permit application. Provide copies of the permit and all supporting information (SWMP, sampling plan, etc).
4) Provide documentation showing Brannan has the authorization to work, store materials or stockpile on Adams County parcel # 0182508100038 located between Brannan and Clear Creek. If there is no written agreement, please relocate the berm or any other containment structure within Brannan property line. Re-store Adams County property: grade, amend soil, mulch and seed until 70% vegetation cover is established and survey and staked down the property limits. Refer to image below.
5) Establish a 150ft vegetation buffer zone from the top of clear Creek's slope. Provide site plan showing buffer zone. Revegetated buffer zone as needed with native seed mix according to soil type.
6) Provide access easement to the county to inspect the creek. Contact ROW-Marissa H.
7) Install a vehicle tracking pad following UDFCD details, angular clean rock 3 to 6", geotextile underneath at the access that transitions from the recycled asphalt driveway and dirt. The millings do not remove sediment from tires, a tracking pad is still needed. Call for inspection. No recycling concrete allowed. This product is not allowed because the fines have high pH and impact water quality.
8) Provide "Sweeping Plan" specifying sweeping frequency. No kick broom equipment, vacuum sweeper is required. Sweeping logs must be filed. Waste disposal of sweepings needs to be specified. If disposal is on-site, provide location and BMPs to prevent run-on, run-off and infiltration of pollutants into the ground.
9) Inspect impacts to Clear Creek's slope regularly. Remove all trash, repair all erosion, mulch and seed all bare soil areas following UDFCD details and seed mix. Document conditions with pictures and keep logs. Provide inspection results and repairs of the first inspection.
10) Contact David Rausch regarding drainage easement needs along the front side of the property, and Drainage issues in that area.

COLORADO
Division of Water Resources
Department of Natural Resources

December 30, 2019

Greg Barnes, Planner III
Adams County Community & Economic Development Department
Transmission via email: gjbarnes@adcogov.org

Re: Brannan Sand & Gravel Pit
Case no. PRC2019-00020
Part of NW ¼ Section 8, T 3S, R 68W, 6th P.M.
Water Division 1, Water District 2

Dear Mr. Barnes:

We have received your December 17, 2019 submittal concerning the above referenced conditional use permit applications for recycling operations, accessory outdoor storage, and stacking of material uses on a 23.57-acre parcel located in the NW ¼ of Section 8, T 3S, R 68W, 6th P.M. According to the submitted information, the parcel is located in the Industrial-2 and Industrial-3 zone districts.

This referral does not appear to qualify as a "subdivision" as defined in Section 30-28-101(10)(a), C.R.S. Therefore, pursuant to the State Engineer's March 4, 2005 and March 11, 2011 memorandums to county planning directors, this office will only perform a cursory review of the referral information and provide informal comments. The comments do not address the adequacy of the water supply plan for this project or the ability of the water supply plan to satisfy any County regulations or requirements. In addition, the comments provided herein cannot be used to guarantee a viable water supply plan or infrastructure, the issuance of a well permit, or physical availability of water.

There are no permitted wells on the property. Estimated water demand, proposed uses, and proposed water supply source were not provided. A letter dated April 3, 2019 stated that the North Washington Street Water & Sanitation District ("District") is currently servicing this property, and that permits for additional uses such as industrial must first be obtained, subject to limitations set forth by the District. This office has no objections to this proposal.

If you or the applicant have any questions, please contact Wenli Dickinson at 303-866-3581 x8206 or at wenli.dickinson@state.co.us.

Sincerely,

Joanna Williams, P.E.
Water Resources Engineer

Ec: Subdivision file 26898

Greg Barnes

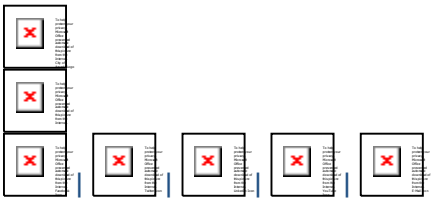
From: Rob Smetana <rsmetana@arvada.org>
Sent: Wednesday, December 18, 2019 3:17 PM
To: Greg Barnes
Subject: Re: For Review: Brannan Sand & Gravel Pit R (PRC2019-00020)

Greg,

Arvada has no concerns regarding this project. It is outside of our Comprehensive Plan and urban growth boundary areas.

Thanks for sending this for our review.

Rob Smetana, AICP
Manager of City Planning and Development
720.898.7440
rsmetana@arvada.org



On Tue, Dec 17, 2019 at 1:05 PM Greg Barnes <GJBarnes@adcogov.org> wrote:

> The Adams County Planning Commission is requesting comments on the following applications: **Conditional use permit applications to allow the following uses in the Industrial-2 and Industrial-3 zone districts: 1) recycling operations, 2) accessory outdoor storage; 3) stacking of material over the height of fencing.** This request is located at 2601 West 60th Avenue. The Assessor's Parcel Number is 0182508100041.
>
> Applicant Information: Brannan, Fred Marvel, 2500 E. Brannan Way, Denver, CO 80229

Please forward any written comments on this application to the Community and Economic Development Department at 4430 S. Adams County Parkway, Suite W2000A Brighton, CO

80601-8216, or call (720) 523-6800 by January 7, 2020 in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to GJBarnes@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional information can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases, sometimes it may take a few business days for case material to get posted to our website.

Thank you for your review of this case.

Greg Barnes

Planner III, *Community and Economic Development Dept.*

ADAMS COUNTY, COLORADO

4430 S. Adams County Parkway, 1st Floor, Suite W2000A

Brighton, CO 80601-8216

720.523.6853 *gjbarnes@adcogov.org*

adcogov.org

Greg Barnes

From: Inter Governmental Plan Review <InterGovernmentalPlanReview@denverwater.org>
Sent: Friday, December 20, 2019 8:29 AM
To: Greg Barnes
Subject: RE: For Review: Brannan Sand & Gravel Pit R (PRC2019-00020)

Good Morning Greg,

Denver Water has no comments on this submittal. Please let me know if you have any questions or concerns.

Thank you,

Kela Naso | Engineering Specialist
Denver Water | t: 303-628-6302 | e: kela.naso@denverwater.org
denverwater.org | denverwaterTAP.org

DENVER WATER

From: Greg Barnes <GJBarnes@adcogov.org>
Sent: Tuesday, December 17, 2019 1:06 PM
To: Greg Barnes <GJBarnes@adcogov.org>
Subject: For Review: Brannan Sand & Gravel Pit R (PRC2019-00020)

The Adams County Planning Commission is requesting comments on the following applications: **Conditional use permit applications to allow the following uses in the Industrial-2 and Industrial-3 zone districts: 1) recycling operations, 2) accessory outdoor storage; 3) stacking of material over the height of fencing.** This request is located at 2601 West 60th Avenue. The Assessor's Parcel Number is 0182508100041.

Applicant Information: Brannan, Fred Marvel, 2500 E. Brannan Way, Denver, CO 80229

Please forward any written comments on this application to the Community and Economic Development Department at 4430 S. Adams County Parkway, Suite W2000A Brighton, CO 80601-8216, or call (720) 523-6800 by January 7, 2020 in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to GJBarnes@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional information can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases, sometimes it may take a few business days for case material to get posted to our website.

Thank you for your review of this case.

ADAMS COUNTY FIRE RESCUE
FIRE PREVENTION BUREAU

7980 Elmwood Lane
Denver, CO 80221
P: (303) 539-6862
E: fireprevention@acfpd.org

Project:	Brannan Sand & Gravel	**Project Type:**	ADCO Conditional Use Permit
Address:	2601 West 60th Avenue	**Date:**	12/23/19
Occupancy Type:	Outdoor recycling, storage, and stacking	**Reviewed By:**	Whitney Even
Construction Type:	TBD	**Certification #:**	166304410

The plans submitted to the Adams County Planning Division have been sent to use for review and comments. At this time, the Fire District has the following comments and/or requirements:

General:

1. The 2018 International Fire Code is the current fire code adopted within the city and all development must be in compliance with its requirements. The 2018 IFC can be accessed online for free by going to https://codes.iccsafe.org/public/document/IFC2018. Amendments to this code can be located by going to http://www.adcogov.org/sites/default/files/Ordinance%20No.%204_1.pdf.

2. Nothing in this review is intended to approve any aspect of these plans or this project that does not strictly comply with all applicable codes and standards. Any changes that are made to the plans will require additional review and comment by the Fire District.

3. Site and building design and construction shall be in accordance with the provisions of the 2018 International Fire Code (IFC) as adopted by Adams County. All construction shall be in accordance with IFC Chapter 33, *Fire Safety During Construction and Demolition*.

Access Requirements:

1. Temporary access roads are prohibited unless specifically approved by the Fire District. Fire apparatus access must be designed and maintained to support the imposed loads of fire apparatus (i.e. 85,000 lbs), and must have a surface that provides all-weather driving capabilities.

2. Any temporary construction or permanent security gates shall be a minimum of 24 feet and a no parking fire lane sign shall be posted on the gate. The gates shall also have a Knox key switch installed for emergency operation if automatic. For information on how to order this, please go to https://www.acfpd.org/plan-submittals.html.

3. If the gas meter is accessible to vehicle impact bollards are required to protect it.

4. New and existing buildings or sites shall have approved address numbers, building numbers, or approved building identification placed in a position that is plainly legible and visible from the street or road fronting the property. These numbers shall contrast with their background. Numbers shall be a minimum of 4 inches high with a minimum stroke width of 0.5 inch. Please be aware that the size of the number may need to be larger than 4 inches is not clearly visible from the street or road.

Fire Protection Water Supply and Hydrants:

5. Please provide information and plans showing the closest fire hydrants to the site.

6. Unobstructed access to fire hydrants shall be maintained at all times. Fire department personnel shall not be deterred or hindered from gaining immediate access to fire protection equipment or fire hydrants. A 3-foot (radius) clear space shall be maintained around the circumference of fire hydrants. Within that 6-foot diameter circle and within a 6-foot-wide path leading to the 4.5-inch outlet of a hydrant, vegetation shall be no higher than 4 inches above grade. The unobstructed vertical clearance within that 6-foot circle and 6-foot approach path shall not be less than 7 feet, unless otherwise approved by the Fire District.

Other Requirements:

⇒ Please be aware that permits for any building structures and gates will be required by the Fire Prevention Bureau. Please call us for information on how to apply.
⇒ We always welcome and encourage meetings to discuss fire code requirements. Please call us at any point in the process if you would like to schedule one.

Any disagreements to these plan review comments may be addressed by contacting the Adams County Fire District offices. Further unresolved disagreements may be appealed to the Adams County Fire Board of Appeals as stated in Ordinance 4 of the amendments to the 2018 International Fire Code.

Greg Barnes

From: Woodruff, Clayton <Clayton.Woodruff@RTD-Denver.com>
Sent: Friday, January 03, 2020 2:27 PM
To: Greg Barnes
Subject: RE - Brannan Sand & Gravel Pit - (PRC2019-00020)

Greg,

The RTD has no comments regarding this project.

C. Scott Woodruff
Engineer III
Regional Transportation District
1560 Broadway, Suite 700, FAS-73 | Denver, CO 80202

o 303.299.2943 | m 303-720-2025
clayton.woodruff@rtd-denver.com

January 3, 2020

Greg Barnes
Adams County Community and Economic Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601

RE: Brannan Sand and Gravel (Pit 10), PRC2019-00020
TCHD Case No. 6065

Dear Mr. Barnes,

Thank you for the opportunity to review and comment on the Conditional Use Permit for recycling operations, accessory outdoor storage, and stacking of materials of the height of the fencing located at 2601 W. 60th Avenue. Tri-County Health Department (TCHD) staff has reviewed the application for compliance with applicable environmental and public health regulations and principles of healthy community design. After reviewing the application, TCHD has the following comments.

Historic Landfill within Adams County Overlay District
In accordance with Section 3-35-03 of Chapter 3-Zone District Regulation, Flammable Gas Overlay (FGO), the subject property will need to comply with all applicable sections of the Adams County Flammable Gas Overlay (FGO). Flammable gas from decomposing organic matter in landfills may travel up to 1,000 feet from the source. At this time, construction is not proposed. At such time that construction is planned within 1,000 feet of Landfill Nos. AD-028, Ad-145, AD-008, AD-027, AD-004, AD-003, AD-234, AD-030, and AD-160, we recommend the following:

1. A flammable gas investigation should be conducted to determine if flammable gas (methane) is present in the subsurface soils at the property. The plan for the investigation should be submitted to TCHD for review and approval.

2. TCHD will review the results of the investigation. If the investigation indicates that methane is not present at or above 20% of the lower explosive limit for methane (1% by volume in air) in the soils, no further action is required.

3. In lieu of the investigation, an active flammable gas control system shall be designed and constructed to protect buildings and subsurface access to utilities, i.e. vaults, manholes, etc. from flammable gas. Health and safety practices shall be followed during construction to protect site workers.

Questions regarding this may be directed to Sheila Lynch at (720) 200-1571 or slynch@tchd.org.

Construction and Demolition Recycling Facility
Recycling of industrial materials has the potential to cause odors, ground water contamination, and nuisance conditions. The Hazardous Materials and Waste Management Division of Colorado Department of Public Health and Environment (CDPHE) regulates recycling facilities. This facility must meet the requirements of Section 8 of 6CCR 1007-2, Part 1. More information can be found at https://www.colorado.gov/pacific/cdphe/recycling.

Fugitive Dust – Permanent uses
Exposure to air pollution is associated with a number of health problems including asthma, lung cancer, and heart disease. The Colorado Department of Public Health and Environment Air Pollution Control Division (APCD) regulates air emissions, including fugitive dust. Control measures may be necessary to minimize the amount of fugitive emissions from site activities including haul roads, stockpiles, and erosion. The applicant shall contact the APCD, at (303) 692-3100 for more information. Additional information is available at https://www.colorado.gov/pacific/cdphe/categories/services-and-information/environment/air-quality/business-and-industry .

Vector Control - Storage
Rodents such as mice and rats carry diseases which can be spread to humans through contact with rodents, rodent feces, urine, or saliva, or through rodent bites. Items stored on the floor, tightly packed, and rarely moved provide potential harborage for rodents. Due to the variety of items to be potentially stored at this site, TCHD recommends that the applicant create a plan for regular pest control. Information on rodent control can be found at http://www.tchd.org/400/Rodent-Control

Please feel free to contact me at 720-200-1575 or kboyer@tchd.org if you have any questions about TCHD's comments.

Sincerely,

Kathy Boyer, REHS
Land Use and Built Environment Specialist III

cc: Sheila Lynch, Monte Deatrich, Lisa Oliveto, Warren Brown, TCHD

Right of Way & Permits
1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571.3284
donna.l.george@xcelenergy.com

January 3, 2020

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Greg Barnes

Re: Brannan Sand and Gravel Pit 10, Case # PRC2019-00020

Public Service Company of Colorado's Right of Way & Permits Referral Desk has reviewed the conditional use documentation for **Brannan Sand and Gravel Pit 10** and has **no apparent conflict**.

Donna George
Right of Way and Permits
Public Service Company of Colorado dba Xcel Energy
Office: 303-571-3306 – Email: donna.l.george@xcelenergy.com

ARMOS Investments
4770 Biscayne Blvd, Ste 730
Miami, FL 33136

Community and Economic Development Department
Adams County
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601-8216
via email: GJBarnes@adcogov.org

RE: PRC2019-00020 Brannan Sand & Gravel (Pit 10)

To Whom It May Concern:

On behalf of 2300 W 60 LLC and 2400 W60 LLC, owners of the properties located at 2300 through 2860 West 60th Avenue, thank you for the opportunity to comment on Project Number PRC2019-00020 and the proposed conditional use permit.

We understand the physical, environmental, regulatory, and market constraints complicating redevelopment of the subject property in a manner more consistent with Adams County long range plans for the area. We also understand that it is likely in both the applicant's and the County's interest for the site to remain economically viable during the interim period while area and regional studies are being completed and a site-specific plan for redevelopment is submitted and approved.

However, as the owners' of the property immediately across the street from the subject property, we feel strongly that if the County approves the proposed conditional use (or any other conditional use) the timeline and terms for achieving a viable plan for redevelopment and the terms for a clear end to the conditional use(s) should be well understood and documented as part of the County's approval.

Since the application itself makes no reference to either a process or a timeline, we respectfully request to be kept informed of the application process, including receiving a copy of the staff report, notice of hearing dates, etc.

Sincerely,

2300W60, LLC, a Florida limited liability company

By: Clear Creek Station Development, LLLP, a Florida limited liability limited partnership
Its: Sole Member

By: CCSD LLC, a Colorado limited liability company
Its: General Partner

By: _____
Print Name: Alexander D. Mashburn
Title: Manager

Greg Barnes

From: Dan Micek <danmicek54@comcast.net>
Sent: Tuesday, December 17, 2019 1:39 PM
To: Greg Barnes
Subject: PRC2019-00020 Brannan Sand and Gravel

Greg
I have received and reviewed the application from Brannan Sand and Gravel.
I believe that this proposal is in line with the comprehensive plan of Adams County.
The land along Clear Creek and I-76 have been set for industrial zoning.
This company has made it clear that they fully intend to follow county regulation and I see no issue with them using this land for their purpose.
The future plans for this area are far reaching, and because of the general condition of the area, probably unattainable.
Since I do not live in the immediate area, I would be curious how the local residents feel about this project and the future plans of this location.

Dan Micek
Citizen
Adams County Colorado

Sent from Mail for Windows 10

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Request for Comments

Case Name: Brannan Sand & Gravel (Pit 10)

Project Number: PRC2019-00020

December 17, 2019

The Adams County Planning Commission is requesting comments on the following applications: **Conditional use permit applications to allow the following uses in the Industrial-2 and Industrial-3 zone districts: 1) recycling operations, 2) accessory outdoor storage; 3) stacking of material over the height of fencing.** This request is located at 2601 West 60th Avenue. The Assessor's Parcel Number is 0182508100041.

Applicant Information: Brannan
Fred Marvel
2500 E. Brannan Way
Denver, CO 80229

Please forward any written comments on this application to the Community and Economic Development Department at 4430 S. Adams County Parkway, Suite W2000A Brighton, CO 80601-8216, or call (720) 523-6800 by January 6, 2020 in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to GJBarnes@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you upon request. The full text of the proposed request and additional information can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Greg Barnes
Planner III

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Public Hearing Notification

Case Name:	Brannan Sand & Gravel
Case Number:	PRC2019-00020
Planning Commission Hearing Date:	July 9, 2020 at 6:00 p.m.
Board of County Commissioners Hearing Date:	July 28, 2020 at 9:30 a.m.

June 17, 2020

A public hearing has been set by the Adams County Planning Commission and the Board of County Commissioners to consider the following request: Conditional use permit applications to allow the following uses in the Industrial-2 and Industrial-3 zone districts: 1) recycling operations, 2) accessory outdoor storage; 3) stacking of material over the height of fencing. The Assessor's Parcel Number is 0182508100041. The site is located at 2601 W. 60th Avenue. The applicant is: Fred Marvel, Brannan, Brannan Sand & Gravel, 2500 E Brannan Way, Denver, CO 80229

The Planning Commission meeting will be held virtually using the Zoom video conferencing software and members of the public will be able to submit comments prior to the start of the public hearing that will then be entered into the record. For instructions on how to access the public hearing via telephone or internet, or to submit comment, please visit http://www.adcogov.org/planning-commission for up to date information.

The Board of County Commissioners meeting is broadcast live on the Adams County YouTube channel and members of the public will be able to submit comments prior to the start of the public hearing that will then be entered into the record. The eComment period opens when the agenda is published and closes at 4:30 p.m. the Monday prior to the noticed meeting. For instructions on how to access the public hearing and submit comments, please visit http://www.adcogov.org/bocc for up to date information.

These will be public hearings and any interested parties may attend and be heard. The Applicant and Representative's presence at these hearings is requested. The full text of the proposed request and additional colored maps can be obtained by accessing the Adams County Community and Economic Development Department website at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Greg Barnes, Planner III
gjbarnes@adcogov.org, 720-523-6853

PUBLICATION REQUEST

Case Name: PRC2019-00020
Case Number: Brannan Sand & Gravel

Planning Commission Hearing Date: July 9, 2020 at 6:00 p.m.
Board of County Commissioners Hearing Date: July 28, 2020 at 9:30 a.m.

Case Manager: Greg Barnes, gjbarnes@adcogov.org, 720-523-6853
Applicant: Fred Marvel, Brannan, Brannan Sand & Gravel, 2500 E Brannan Way, Denver, CO 80229

Request: Conditional use permit applications to allow the following uses in the Industrial-2 and Industrial-3 zone districts: 1) recycling operations, 2) accessory outdoor storage; 3) stacking of material over the height of fencing.

Parcel Number: 0182508100041
Address of the Request: 2601 W. 60th Avenue
Legal Description: A PARCEL OP LAND LYING IN THE NORTHEAST 1/4 OF SECTION 8, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF SAID SECTION 8, THENCE SOUTH O0 DEGREES 07 MINUTES 03 SECONDS EAST, 1650.60 FEET ALONG THE EAST LINE OF SAID SECTION 8 TO A POINT ON THE SOUTH LINE OF THAT PARCEL OF LAND AS DESCRIBED IN BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS, SAID POINT BEING THE TRUE POINT OF BEGINNING; THENCE SOUTH 00 DEGREES 07 MINUTES 03 SECONDS EAST ALONG THE EAST LINE OF SAID SECTION 8 920.29 FEET TO A POINT ON THE NORTH LINE OF THAT PARCEL OP LAND AS DESCRIBED IN BOOK 3374, PAGE 318, ADAMS COUNTY RECORDS, THENCE SOUTH 86 DEGREES 54 MINUTES 20 SECONDS WEST ALONG SAID NORTH LINE 169.81 FEET; THENCE SOUTH 78 DEGREES 58 MINUTES 16 SECONDS WEST ALONG SAID NORTH LINE 56.02 FEET TO THE NORTH LINE OF THAT PARCEL OF LAND AS DESCRIBED IN BOOK 3432, PAGE 154, ADAMS COUNTY RECORDS; THENCE NORTH 89 DEGREES 58 MINUTES 13 SECONDS WEST ALONG SAID NORTH, LINE 1411.70 FEET; THENCE SOUTH 49 DEGREES 53 MINUTES 18 SECONDS WEST ALONG THE NORTHWESTERLY LINE OF SAID PARCEL OF LAND DESCRIBED IN BOOK 3432, PAGE 154 A DISTANCE OF 77.56 FEET TO THE EAST-WEST CENTERLINE OF SAID SECTION 8; THENCE NORTH 89 DEGREES 58 MINUTES 13 SECONDS WEST ALONG SAID EAST-WEST CENTERLINE 183.64 FEET MORE OR LESS TO THE SOUTHERLY LINE OF THAT PARCEL OF LAND AS DESCRIBED IN BOOK 4180, PAGE 409, ADAMS COUNTY RECORDS; THENCE NORTHEASTERLY ALONG SAID SOUTHERLY LINE THE FOLLOWING SIX COURSES: 1. NORTH 49 DEGREES 25 MINUTES 25 SECONDS EAST, 122.50 FEET; 2. NORTH 47 DEGREES 42 MINUTES 36 SECONDS EAST, 356.79 FEET; 3. THENCE ALONG A CURVE TO THE RIGHT HAVING A RADIUS OF 433.51 FEET AND A CENTRAL ANGLE OF 11 DEGREES 59 MINUTES 07 SECONDS; 4. NORTH 59 DEGREES 41 MINUTES 43 SECONDS FAST, 331.34 FEET; 5. NORTH 68 DEGREES 33 MINUTES 27 SECONDS EAST, 1080.62 FEET; 6. NORTH 72 DEGREES 24 MINUTES 16 SECONDS EAST, 155.30 FEET TO THE TRUE POINT OF BEGINNING.

Virtual Meeting and Public Comment Information:
These meetings will be held virtually. Please visit http://www.adcogov.org/planning-commission and http://www.adcogov.org/bocc for up to date information on accessing the public hearings and

submitting comment prior to the hearings. The full text of the proposed request and additional colored maps can be obtained by accessing the Adams County Community and Economic Development Department website at www.adcogov.org/planning/currentcases.

Adams County Attorney's Office
Attn: Christine Fitch
4430 S Adams County Pkwy
Brighton CO 80601

Adams County CEDD Addressing
Attn: Mark Alessi
PLN

Adams County CEDD Development Services Engineer
Attn: Devt. Services Engineering
4430 S. Adams County Pkwy.
Brighton CO 80601

Adams County CEDD Right-of-Way
Attn: Mark Alessi
4430 S. Adams County Pkwy.
Brighton CO 80601

Adams County Community & Economic Development Departm
Attn: Gina Maldonado
4430 S. Adams County Pkwy
Brighton CO 80601

Adams County Community Safety & Wellbeing, Neighborhood
Attn: Gail Moon
4430 S. Adams County Pkwy.
Brighton CO 80601

Adams County Construction Inspection
Attn: Gordon .Stevens
4430 S. Adams County Pkwy
Brighton CO 80601

Adams County Development Services - Building
Attn: Justin Blair
4430 S Adams County Pkwy
Brighton CO 80601

Adams County Fire Protection District
Attn: Jerry Means
8055 N. WASHINGTON ST.
DENVER CO 80229

Adams County Fire Rescue
Attn: Whitney Even
7980 Elmwood Lane
Denver CO 80221

Adams County Parks and Open Space Department
Attn: Marc Pedrucci

Adams County Parks and Open Space Department
Attn: Aaron Clark

Adams County Sheriff's Office
Attn: Rick Reigenborn

Adams County Sheriff's Office
Attn: - -

Adams County Treasurer
Attn: Lisa Culpepper
4430 S. Adams County Pkwy.
Brighton CO 80601

Arvada Fire Department
Attn: Steven Parker
7903 Alison Way
Arvada CO 80005

BERKELEY NEIGHBORHOOD ASSOC.
Attn: GLORIA RUDDEN
4420 W 52ND PL.
DENVER CO 80212

BERKELEY WATER
Attn: Paul Peloquin
4455 W 58TH AVE UNIT A
Arvada CO 80002

BERKELEY WATER & SAN DISTRICT
Attn: SHARON WHITEHAIR
4455 W 58TH AVE UNIT A
ARVADA CO 80002

CDOT Colorado Department of Transportation
Attn: Bradley Sheehan
2829 W. Howard Pl.
2nd Floor
Denver CO 80204

Century Link, Inc
Attn: Brandyn Wiedreich
5325 Zuni St, Rm 728
Denver CO 80221

City of Arvada
Attn: Rob Smetana
8101 Ralston Rd.
Arvada CO 80002

City of Arvada Utilities
Attn: Sharon Israel
8101 Ralston Rd.
Arvada CO 80002

CITY OF WESTMINSTER
Attn: Rita McConnell
4800 W 92ND AVE.
WESTMINSTER CO 80031

CITY OF WESTMINSTER
Attn: Andy Walsh
4800 W 92nd Avenue
WESTMINSTER CO 80031

COLO DIV OF WATER RESOURCES
Attn: Joanna Williams
OFFICE OF STATE ENGINEER
1313 SHERMAN ST., ROOM 818
DENVER CO 80203

COLO DIV OF WATER RESOURCES
Attn: Joanna Williams
OFFICE OF STATE ENGINEER
1313 SHERMAN ST., ROOM 818
DENVER CO 80203

COLORADO DEPT OF TRANSPORTATION
Attn: Steve Loeffler
2000 S. Holly St.
Region 1
Denver CO 80222

COLORADO DIVISION OF WILDLIFE
Attn: Matt Martinez
6060 BROADWAY
DENVER CO 80216-1000

COLORADO DIVISION OF WILDLIFE
Attn: Serena Rocksund
6060 BROADWAY
DENVER CO 80216

COLORADO GEOLOGICAL SURVEY
Attn: Jill Carlson
1500 Illinois Street
Golden CO 80401

Colorado Geological Survey: CGS_LUR@mines.edu
Attn: Jill Carlson
Mail CHECK to Jill Carlson

COMCAST
Attn: JOE LOWE
8490 N UMITILLA ST
FEDERAL HEIGHTS CO 80260

Crestview Water & Sanitation
Attn: Patrick Stock
7145 Mariposa St
PO Box 21299
Denver CO 80221-0299

Division of Mining and Reclamation Safety
Attn: Jared Ebert
Colorado Department of Natural Resources
1313 Sherman St., #215
Denver CO 80203

GOAT HILL
Attn: SHARON WHITEHAIR
2901 W 63RD
AVE SP:0047
DENVER CO 80221

MAPLETON SCHOOL DISTRICT #1
Attn: CHARLOTTE CIANCIO
591 E. 80TH AVE
DENVER CO 80229

METRO WASTEWATER RECLAMATION
Attn: CRAIG SIMMONDS
6450 YORK ST.
DENVER CO 80229

MOBILE GARDENS
Attn: VERA MARIE JONES
6250 FEDERAL #29
DENVER CO 80221

North Lincoln Water and Sanitation District
Attn: JORGE HINOJOS
1560 Broadway
Suite 1400
Denver CO 80202

North Lincoln Water and Sanitation District
Attn: - -

North Pecos Water & Sanitation District
Attn: Russell Traska
6900 Pecos St
Denver CO 80221

NORTHRIDGE ESTATES AT GOLD RUN HOA
Attn: SHANE LUSSIER
14901 E Hampden Ave
Suite 320
AURORA CO 80014

NS - Code Compliance
Attn: Kerry Gress
kgress@adcogovorg

Pecos Park Logistics Park Metro District
Attn: M Mitchell
4221 Brighton Blvd
Denver CO 802163719

PERL MACK NEIGHBORHOOD GROUP
Attn: DAN MICEK - PRESIDENT
7294 NAVAJO ST.
DENVER CO 80221

Pomponio Terrace Metropolitan District
Attn: Zachary White
2154 E. Commons Avenue, #2000
Centennial CO 80122

REGIONAL TRANSPORTATION DIST.
Attn: Engineering RTD
1560 BROADWAY SUITE 700
DENVER CO 80202

The TOD Group
Attn: THE TOD GROUP
1431 Euterpe Street
New Orleans LA 70130

TRI-COUNTY HEALTH DEPARTMENT
Attn: Sheila Lynch
6162 S WILLOW DR, SUITE 100
GREENWOOD VILLAGE CO 80111

TRI-COUNTY HEALTH DEPARTMENT
Attn: MONTE DEATRICH
4201 E. 72ND AVENUE SUITE D
COMMERCE CITY CO 80022

Tri-County Health: Mail CHECK to Sheila Lynch
Attn: Tri-County Health
landuse@tchd.org

UNION PACIFIC RAILROAD
Attn: Anna Dancer
1400 DOUGLAS ST STOP 1690
OMAHA NE 68179

United States Postal Service
Attn: Arlene Vickrey

United States Postal Service
Attn: Jason Eddleman

US EPA
Attn: Stan Christensen
1595 Wynkoop Street
DENVER CO 80202

WESTMINSTER FIRE DEPT.
Attn: CAPTAIN DOUG HALL
9110 YATES ST.
WESTMINSTER CO 80031

WESTMINSTER SCHOOL DISTRICT #50
Attn: Jackie Peterson
7002 Raleigh Street
WESTMINSTER CO 80030

Xcel Energy
Attn: Donna George
1123 W 3rd Ave
DENVER CO 80223

Xcel Energy
Attn: Donna George
1123 W 3rd Ave
DENVER CO 80223

2300W60 LLC
C/O CCSD-COLORADO LLC
4770 BISCAYNE BLVD STE 700
MIAMI FL 33137-3244

2400W60 LLC
C/O CCSD- COLORADO LLC
4770 BISCAYNE BLVD STE 710
MIAMI FL 33137-3244

5999 PECOS LLC UND 92.1875% AND
ACJW LLC UND 7.8125% INT
4880 PEARL ST
BOULDER CO 80301-2454

6232 BEACH LLC
PO BOX 1719
ARVADA CO 80001-1719

67TH STREET ACQUISITIONS LLC
500 W 67TH STREET
LOVELAND CO 80538

ADAMS COUNTY
4430 SOUTH ADAMS COUNTY PKWY
BRIGHTON CO 80601-8204

ADAMS COUNTY
4430 S ADAMS COUNTY PKWY
BRIGHTON CO 80601

ALOHA BEACH DEVELOPMENT CORP
3556 W 62ND AVENUE
DENVER CO 80221

APODACA FAMILY REALTY TRUST THE
2241 W 59TH PLACE
DENVER CO 80221

ATR HOLDINGS LLC
13490 IVY ST
THORNTON CO 80602-9223

BEACH62 LLC
3535 LARIMER ST
DENVER CO 80205-2421

BERKELEY POINTE LLC
2405 W 56TH AVE
DENVER CO 80221-1809

BOARD OF COUNTY COMMISSIONERS OF
ADAMS COUNTY
4430 SOUTH ADAMS COUNTY PKWY
BRIGHTON CO 80601-8204

CARRASCO MARIA P
2360 W 58TH AVE
DENVER CO 80221

CC W64TH AVE LLC
4007 BRYANT ST
DENVER CO 80211-2117

CHERFEIN JOINT VENTURE LLC
3535 LARIMER ST
DENVER CO 80205-2421

CIROCKI VIOLA M TRUST THE UND 64.4% AND
CIROCKI FAMILY TRUST THE UND 35.6% INT
8610 HOLMAN CIRCLE
ARVADA CO 80005-5957

COUNTY OF ADAMS
4430 S ADAMS COUNTY PKWY FL 5
BRIGHTON CO 80601-8222

COUNTY OF ADAMS THE
4430 S ADAMS COUNTY PKWY
BRIGHTON CO 80601-8222

COUNTY OF ADAMS THE
4430 SOUTH ADAMS COUNTY PKWY
BRIGHTON CO 80601-8204

CST METRO LLC
1 VALERO WAY
SAN ANTONIO TX 78249-1616

DEEDS BETH A
8800 GROVE ST
WESTMINSTER CO 80031-3329

DENNIS PROPERTIES LLC
8175 W CLIFTON AVE
LITTLETON CO 80128-5587

DENVER TRANSIT ORIENTED DEVELOPMENT FUND LLC
1431 EUTERPE ST
NEW ORLEANS LA 70130-4405

DISNER PATRICK HENRY AND
DISNER KATHLEEN I
250 CARRICO ST
PAGOSA SPRINGS CO 81147

EGLI JAMES E
6231 BEACH STREET UNIT C
DENVER CO 80221

ELMS BLESSING LLC
14580 W 56TH PL
ARVADA CO 80002-1154

ELMS BLESSING LLC
C/O FRED J ELMS, MANAGING MEMBER
14580 W 56TH PLACE
ARVADA CO 80002

FED57 LLC
3535 LARIMER ST
DENVER CO 80205-2421

FED58 LLC
3535 LARIMER ST
DENVER CO 80205-2421

FED60 LLC
3535 LARIMER ST
DENVER CO 80205-2421

FED61 LLC
3535 LARIMER ST
DENVER CO 80205-2421

FED62 LLC
3535 LARIMER ST
DENVER CO 80205-2421

GRAEME JOHNSTON LLC
PO BOX 3717
DILLON CO 80435-3717

GWE L P
6320 BEACH STREET
DENVER CO 80221

HEPP MICHAEL J
13937 LEXINGTON PL
WESTMINSTER CO 80023-9386

HOLDCROFT EDWARD
8343 ADAMS WAY
DENVER CO 80221-3905

HOWARD GREGORY A TRUST THE AND
HOWARD KAREN R TRUST THE
10789 BRYANT COURT
WESTMINSTER CO 80234

JUNG CHUL W
6231 FEDERAL BLVD
DENVER CO 80221-2005

JUNG CHUL WOO
6231 N FEDERAL BLVD
DENVER CO 80221

KING LYNETTA ARCHER
412 CHALET DR
BLACK HAWK CO 80422-8722

MARTIN MARIETTA MATERIALS INC
C/O BADEN TAX MANAGEMENT
FORT WAYNE IN 46898-8040

MATHIAS ERIC J AND
MATHIAS KARLA A
6271 BEACH ST UNIT B
DENVER CO 80221-2072

MINER JOHN
PO BOX 577
CASTLE ROCK CO 80104-0577

MOBILE GARDENS LLC
31200 NORTHWESTERN HWY
FARMINGTON HILLS MI 48334-5900

NORTHRIDGE ESTATES AT GOLD RUN
HOMEOWNERS ASSOCIATION
2305 CANYON BLVD SUITE 200
BOULDER CO 80302

PATRICK DEWEY R AND
PATRICK RHONDA A
9520 S FIELD WAY
LITTLETON CO 80127

PECOS LOGISTICS PARK LLLP
4221 BRIGHTON BLVD
DENVER CO 80216-3719

PIONEER MHP LLC 86% INT AND
WAYSIDE COLORADO LLC 14% INT
49 SW FLAGLER AVE STE 201
STUART FL 34994-2148

PIT 10 LLC
2500 E BRANNAN WY
DENVER CO 80229

PULL-N-SAVE AUTO PARTS LLC
5846 CROSSINGS BLVD
ANTIOCH TN 37013-3129

PULL-N-SAVE AUTO PARTS LLC
1550 N MEADOWCREST BLVD
CRYSTAL RIVER FL 34429-5756

QUIKRETE COMPANIES INC THE
C/O KAREN KULP
3490 PIEDMONT RD STE 1300
ATLANTA GA 30305-4811

QUIKRETE COMPANIES INC THE
C/O KAREN KULP
5 CONCOURSE PKWY STE 1900
ATLANTA GA 30328-6111

RBR PROPERTIES LLC
6202 BEACH ST
DENVER CO 80221-2033

REEFER WARE LLC
3535 LARIMER ST
DENVER CO 80205-2421

REGIONAL TRANSPORTATION DISTRICT
1600 BLAKE ST
DENVER CO 80202-1399

RHINER GERALD
5015 W 69TH AVE
WESTMINSTER CO 80030-5711

ROHRER BROTHERS LLC
PO BOX 61035
DENVER CO 80206-1035

SHOTCRETE YARD LLC
8250 S ALBION ST
CENTENNIAL CO 80122-3909

SILVER HOLDINGS LLC
2150 W 60TH AVE APT S
DENVER CO 80221-6623

STATE HIGHWAY DEPT
2000 S HOLLY ST
DENVER CO 80222-4818

STEP 13 INC
2029 LARIMER ST
DENVER CO 80205-2014

UNION PACIFIC RAILROAD
PROPERTY TAX DEPARTMENT
1400 DOUGLAS STOP 1640
OMAHA NE 68179-1640

UNION PACIFIC RAILROAD COMPANY
C/O PROPERTY TAX DEPARTMENT
1400 DOUGLAS STOP 1690
OMAHA NE 68179-1640

VALDEZ RICHARD T AND
VALDEZ BARBARA G
2341 W 58TH AVE
DENVER CO 80221-1827

WEST SPANISH CONGREGATION OF JEHOVAH S
WITNESSES/ C/O MANUEL MENDEZ
2675 W 56TH AVE
DENVER CO 80221-1811

6141 FEDERAL BLVD LLC
OR CURRENT RESIDENT
6141 FEDERAL BLVD
DENVER CO 80221

AABAK ED
OR CURRENT RESIDENT
5781 CLAY STREET
DENVER CO 80221

APODACA GIL S
OR CURRENT RESIDENT
2241 W 59TH PL
DENVER CO 80221-6614

ARROYOS EDUARDO
OR CURRENT RESIDENT
2661 W 58TH AVE
DENVER CO 80221-1854

AVILA LYDIA AND OLIVAS-AVILA KAILEEN LIZETTE
AND
OLIVAS-AVILA BYANKA YAZMIN
OR CURRENT RESIDENT
2681 W 58TH AVE
DENVER CO 80221-1854

CANO IMELDA AND
CANO DELORES
OR CURRENT RESIDENT
2381 W 59TH PL
DENVER CO 80221-1834

CARDOZA JOSE LIUS GUERECA
OR CURRENT RESIDENT
2270 W 59TH PL
DENVER CO 80221-6615

CHAVEZ ALEJANDRO BARRAZA
OR CURRENT RESIDENT
2551 W 58TH AVENUE
DENVER CO 80221

CHOICE IV INVESTMENTS LLP
OR CURRENT RESIDENT
2080 W 60TH AVE
DENVER CO 80221-6631

CLARK JAMES ROBERT FAMILY TRUST THE
OR CURRENT RESIDENT
2300 W 59TH PL
DENVER CO 80221-1835

COWAN DAVID E AND
COWAN GAIL LEONE
OR CURRENT RESIDENT
2291 W 59TH PL
DENVER CO 80221-6614

CROWLEY DAVID P AND
CROWLEY LORRAINE K
OR CURRENT RESIDENT
2450 W 63RD CT
DENVER CO 80221-2031

DECKER JOHN L AND
DECKER DIANNA L
OR CURRENT RESIDENT
2341 W 59TH PL
DENVER CO 80221-1834

DIETZ ERIC
OR CURRENT RESIDENT
2230 W 59TH PL
DENVER CO 80221-6613

EGLI JAMES E
OR CURRENT RESIDENT
6231 BEACH STREET UNIT C
DENVER CO 80221

GLOECKLER AARON AND
GLOECKLER KELLY
OR CURRENT RESIDENT
6271 BEACH ST UNIT F
DENVER CO 80221-2072

HERNANDEZ JOEL DIAZ
OR CURRENT RESIDENT
6271 BEACH ST UNIT D
DENVER CO 80221-2072

HERNANDEZ JOHN A AND
HERNANDEZ GERALDINE
OR CURRENT RESIDENT
2641 W 58TH AVE
DENVER CO 80221-1854

L NOTHHAFT AND SON INC
OR CURRENT RESIDENT
2520 W 62ND CT
DENVER CO 80221-2030

MALLORY SEAN
OR CURRENT RESIDENT
2250 W 59TH PL
DENVER CO 80221-6615

MARTINEZ ALBERT V JR
OR CURRENT RESIDENT
2271 W 59TH PL
DENVER CO 80221-6614

MATHIAS AND MELTON LLC
OR CURRENT RESIDENT
6271 BEACH STREET C
DENVER CO 80221

MATHIAS ERIC J AND
MATHIAS KARLA A
OR CURRENT RESIDENT
6271 BEACH ST UNIT B
DENVER CO 80221-2072

MONDRAGON AUGUSTINE ROBERT AND
MONDRAGON DORIS F
OR CURRENT RESIDENT
2531 W 58TH AVE
DENVER CO 80221

RBR PROPERTIES LLC
OR CURRENT RESIDENT
6202 BEACH ST
DENVER CO 80221-2033

RWF ENTERPRISES LLC
OR CURRENT RESIDENT
2510 W 63RD CT
DENVER CO 80221-2031

SANCHEZ LOYA CARMEN AND
RODRIGUEZ RAFAEL J
OR CURRENT RESIDENT
2391 W 59TH PL
DENVER CO 80221-1834

SILVER HOLDINGS LLC
OR CURRENT RESIDENT
2150 W 60TH AVE
DENVER CO 80221-6623

SUFI IMRAN
OR CURRENT RESIDENT
2591 W 58TH AVE
DENVER CO 80221-1854

TRAN TRUNG Q AND
TRAN THY N
OR CURRENT RESIDENT
2621 W 58TH AVE
DENVER CO 80221

VALDEZ RICHARD T AND
VALDEZ BARBARA G
OR CURRENT RESIDENT
2341 W 58TH AVE
DENVER CO 80221-1827

VAZQUEZ JOSE LUIS AND
VAZQUEZ MARIA R
OR CURRENT RESIDENT
2571 W 58TH AVE
DENVER CO 80221-1854

VIGIL JUAN E II
OR CURRENT RESIDENT
2301 W 59TH PL
DENVER CO 80221-1834

WEST SPANISH CONGREGATION OF JEHOVAH S
WITNESSES/ C/O MANUEL MENDEZ
OR CURRENT RESIDENT
2675 W 56TH AVE
DENVER CO 80221-1811

YOUNG JAMES FRANK AND
YOUNG STEVEN DAVID
OR CURRENT RESIDENT
2290 W 59TH PL
DENVER CO 80221-6615

CURRENT RESIDENT
5855 FEDERAL BLVD
DENVER CO 80221-1805

CURRENT RESIDENT
5800 FEDERAL BLVD
DENVER CO 80221-1806

CURRENT RESIDENT
2685 W 56TH AVE
DENVER CO 80221-1811

CURRENT RESIDENT
5901 FEDERAL BLVD
DENVER CO 80221-1813

CURRENT RESIDENT
2860 W 60TH AVE
DENVER CO 80221-1818

CURRENT RESIDENT
2400 W 60TH AVE
DENVER CO 80221-1825

CURRENT RESIDENT
5900 FEDERAL BLVD UNIT A
DENVER CO 80221-1872

CURRENT RESIDENT
5900 FEDERAL BLVD UNIT B
DENVER CO 80221-1872

CURRENT RESIDENT
3061 W 58TH AVE
DENVER CO 80221-1902

CURRENT RESIDENT
3060 W 58TH AVE
DENVER CO 80221-1905

CURRENT RESIDENT
2901 W 63RD AVE LOT 32A
DENVER CO 80221-2000

CURRENT RESIDENT
2901 W 63RD AVE LOT 33A
DENVER CO 80221-2000

CURRENT RESIDENT
2901 W 63RD AVE LOT 34A
DENVER CO 80221-2000

CURRENT RESIDENT
2901 W 63RD AVE LOT 35A
DENVER CO 80221-2000

CURRENT RESIDENT
2901 W 63RD AVE LOT 36A
DENVER CO 80221-2000

CURRENT RESIDENT
2901 W 63RD AVE LOT 37A
DENVER CO 80221-2000

CURRENT RESIDENT
2901 W 63RD AVE LOT 38A
DENVER CO 80221-2000

CURRENT RESIDENT
6000 FEDERAL BLVD
DENVER CO 80221-2002

CURRENT RESIDENT
6199 FEDERAL BLVD
DENVER CO 80221-2003

CURRENT RESIDENT
6100 FEDERAL BLVD
DENVER CO 80221-2004

CURRENT RESIDENT
6201 FEDERAL BLVD
DENVER CO 80221-2005

CURRENT RESIDENT
6231 FEDERAL BLVD
DENVER CO 80221-2005

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 1
DENVER CO 80221-2009

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 10
DENVER CO 80221-2009

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 11
DENVER CO 80221-2009

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 12
DENVER CO 80221-2009

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 13
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 14
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 15
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 16
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 17
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 18
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 19
DENVER CO 80221-2009

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 2
DENVER CO 80221-2009

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 20
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 3
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 4
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 5
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 6
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 7
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 8
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 9
DENVER CO 80221-2009

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6250 FEDERAL BLVD LOT 21
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 22
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 23
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6250 FEDERAL BLVD LOT 24
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 25
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 26
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6250 FEDERAL BLVD LOT 27
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 28
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 29
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 30
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 31
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 32
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 33
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 34
DENVER CO 80221-2010

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 35
DENVER CO 80221-2010

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 36
DENVER CO 80221-2010

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 37
DENVER CO 80221-2010

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 38
DENVER CO 80221-2010

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6250 FEDERAL BLVD LOT 39
DENVER CO 80221-2010

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 40
DENVER CO 80221-2010

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 41
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 42
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 43
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 44
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 45
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 46
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 47
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 48
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 49
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 50
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 51
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 52
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 53
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 54
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 55
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 56
DENVER CO 80221-2011

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6250 FEDERAL BLVD LOT 57
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 58
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 59
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 60
DENVER CO 80221-2011

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 61
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 62
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 63
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 64
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 65
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 66
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 67
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 68
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 69
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 70
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 71
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 72
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 73
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 74
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 75
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 76
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 77
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 78
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 79
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 80
DENVER CO 80221-2012

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 100
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 81
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 82
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 83
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 84
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 85
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 86
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 87
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 88
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 89
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 90
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 91
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 92
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 93
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 94
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 95
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 96
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 97
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 98
DENVER CO 80221-2013

CURRENT RESIDENT
6250 FEDERAL BLVD LOT 99
DENVER CO 80221-2013

CURRENT RESIDENT
6140 FEDERAL BLVD
DENVER CO 80221-2014

CURRENT RESIDENT
6150 FEDERAL BLVD
DENVER CO 80221-2014

CURRENT RESIDENT
6160 FEDERAL BLVD
DENVER CO 80221-2014

CURRENT RESIDENT
6190 FEDERAL BLVD
DENVER CO 80221-2014

CURRENT RESIDENT
2901 W 63RD AVE OFC OFC
DENVER CO 80221-2016

CURRENT RESIDENT
6001 FEDERAL BLVD BLDG B
DENVER CO 80221-2022

CURRENT RESIDENT
2901 W 63RD AVE LOT 31A
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 31B
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 31C
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 31D
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 31E
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 31F
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 31G
DENVER CO 80221-2024

CURRENT RESIDENT
2901 W 63RD AVE LOT 88
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 89
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 90
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 91
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 92
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 93
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 94
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 95
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 96
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 97
DENVER CO 80221-2026

CURRENT RESIDENT
2901 W 63RD AVE LOT 98
DENVER CO 80221-2026

CURRENT RESIDENT
2430 W 62ND CT
DENVER CO 80221-2030

CURRENT RESIDENT
6331 BEACH ST
DENVER CO 80221-2032

CURRENT RESIDENT
6351 BEACH ST
DENVER CO 80221-2032

CURRENT RESIDENT
6232 BEACH ST
DENVER CO 80221-2033

CURRENT RESIDENT
2880 W 62ND AVE
DENVER CO 80221-2046

CURRENT RESIDENT
2890 W 62ND AVE
DENVER CO 80221-2046

CURRENT RESIDENT
2901 W 63RD AVE LOT 1
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 10
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 12
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 14
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 15
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 16
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 17
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 18
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 19
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 1A
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 2
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 20
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 3
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 3A
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 4
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 5
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 6
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 7
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 8
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 9
DENVER CO 80221-2063

CURRENT RESIDENT
2901 W 63RD AVE LOT 21
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 22
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 23
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 24
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 25
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 26
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 27
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 28
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 29
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 30
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 31
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 32
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 33
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 34
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 35
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 36
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 37
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 38
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 39
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 40
DENVER CO 80221-2064

CURRENT RESIDENT
2901 W 63RD AVE LOT 41
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 42
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 43
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 44
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 45
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 46
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 47
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 48
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 49
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 50
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 51
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 52
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 53
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 54
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 55
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 56
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 57
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 58
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 59
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 60
DENVER CO 80221-2065

CURRENT RESIDENT
2901 W 63RD AVE LOT 61
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 62
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 63
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 64
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 65
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 66
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 67
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 68
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 69
DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 72
DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

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DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 76
DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
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DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 82
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 83
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 84
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 85
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 86
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 87
DENVER CO 80221-2066

CURRENT RESIDENT
2901 W 63RD AVE LOT 11
DENVER CO 80221-2067

CURRENT RESIDENT
6271 BEACH ST UNIT A
DENVER CO 80221-2072

CURRENT RESIDENT
6271 BEACH ST UNIT E
DENVER CO 80221-2072

CURRENT RESIDENT
6271 BEACH ST UNIT G
DENVER CO 80221-2072

CURRENT RESIDENT
6231 BEACH ST UNIT A
DENVER CO 80221-2073

CURRENT RESIDENT
6231 BEACH ST UNIT B
DENVER CO 80221-2073

CURRENT RESIDENT
6231 BEACH ST UNIT D
DENVER CO 80221-2073

CURRENT RESIDENT
2400 W 64TH AVE
DENVER CO 80221-2325

CURRENT RESIDENT
2660 W 64TH AVE
DENVER CO 80221-2330

CURRENT RESIDENT
2600 W 62ND AVE
DENVER CO 80221-2466

CURRENT RESIDENT
2211 W 59TH PL
DENVER CO 80221-6614

CURRENT RESIDENT
2231 W 59TH PL
DENVER CO 80221-6614

CURRENT RESIDENT
2200 W 60TH AVE UNIT A
DENVER CO 80221-6621

CURRENT RESIDENT
2200 W 60TH AVE UNIT B
DENVER CO 80221-6621

CURRENT RESIDENT
2200 W 60TH AVE UNIT C
DENVER CO 80221-6621

CURRENT RESIDENT
2200 W 60TH AVE UNIT D
DENVER CO 80221-6621

CURRENT RESIDENT
2200 W 60TH AVE UNIT E
DENVER CO 80221-6621

CURRENT RESIDENT
2200 W 60TH AVE UNIT F
DENVER CO 80221-6621

CURRENT RESIDENT
2180 W 60TH AVE
DENVER CO 80221-6623

CURRENT RESIDENT
2000 W 60TH AVE
DENVER CO 80221-6631

CURRENT RESIDENT
5929 PECOS ST
DENVER CO 80221-6646

CERTIFICATE OF POSTING

I, J. Gregory Barnes do hereby certify that I posted the property at 2601 W. 60th Avenue on June 23, 2020, in accordance with the requirements of the Adams County Development Standards and Regulations.

J. Gregory Barnes

Brannan Sand & Gravel

PRC2019-00020

2601 W. 60th Avenue

September 1, 2020

Board of County Commissioners Public Hearing

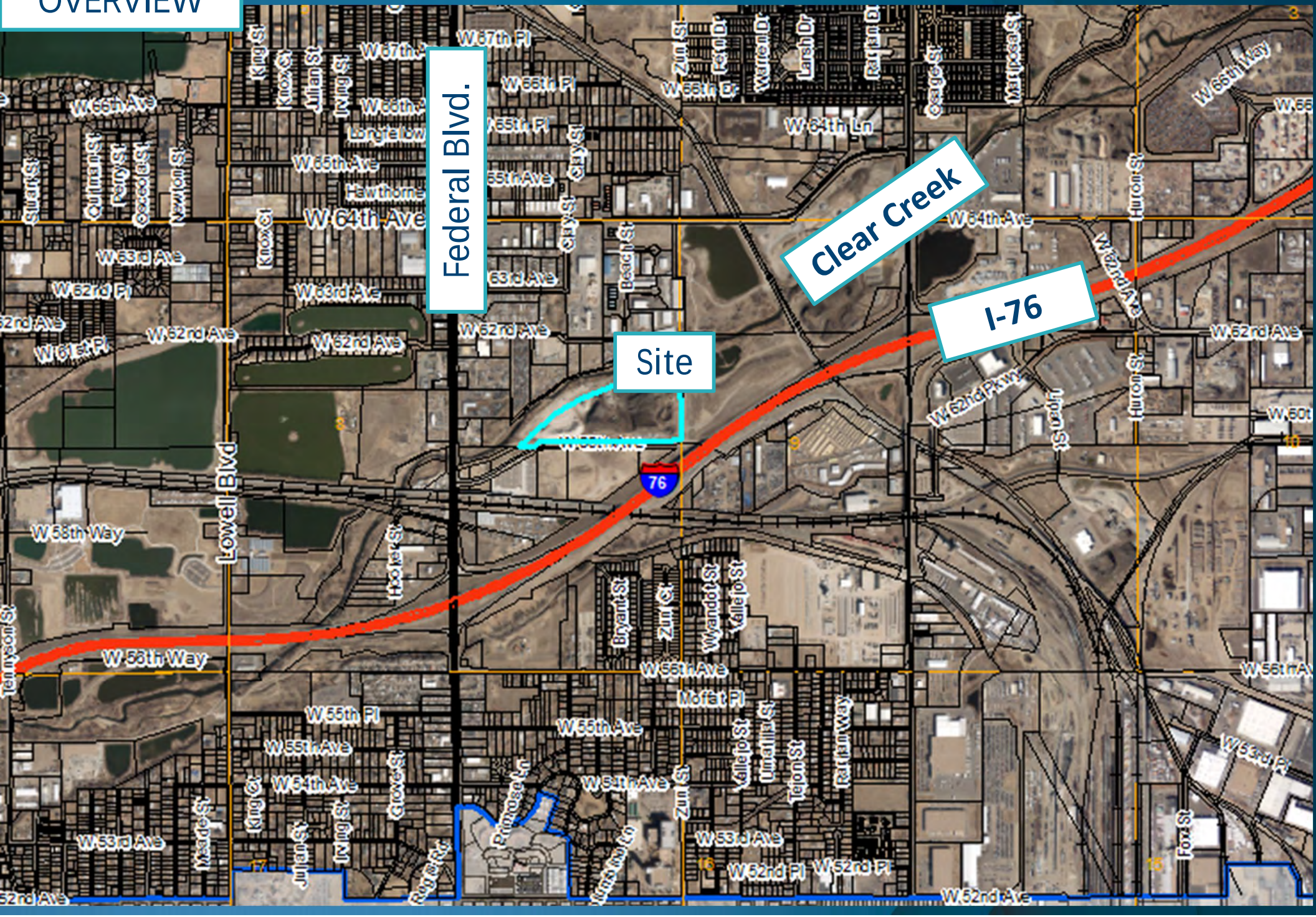
Community and Economic Development Department

Case Manager: Greg Barnes

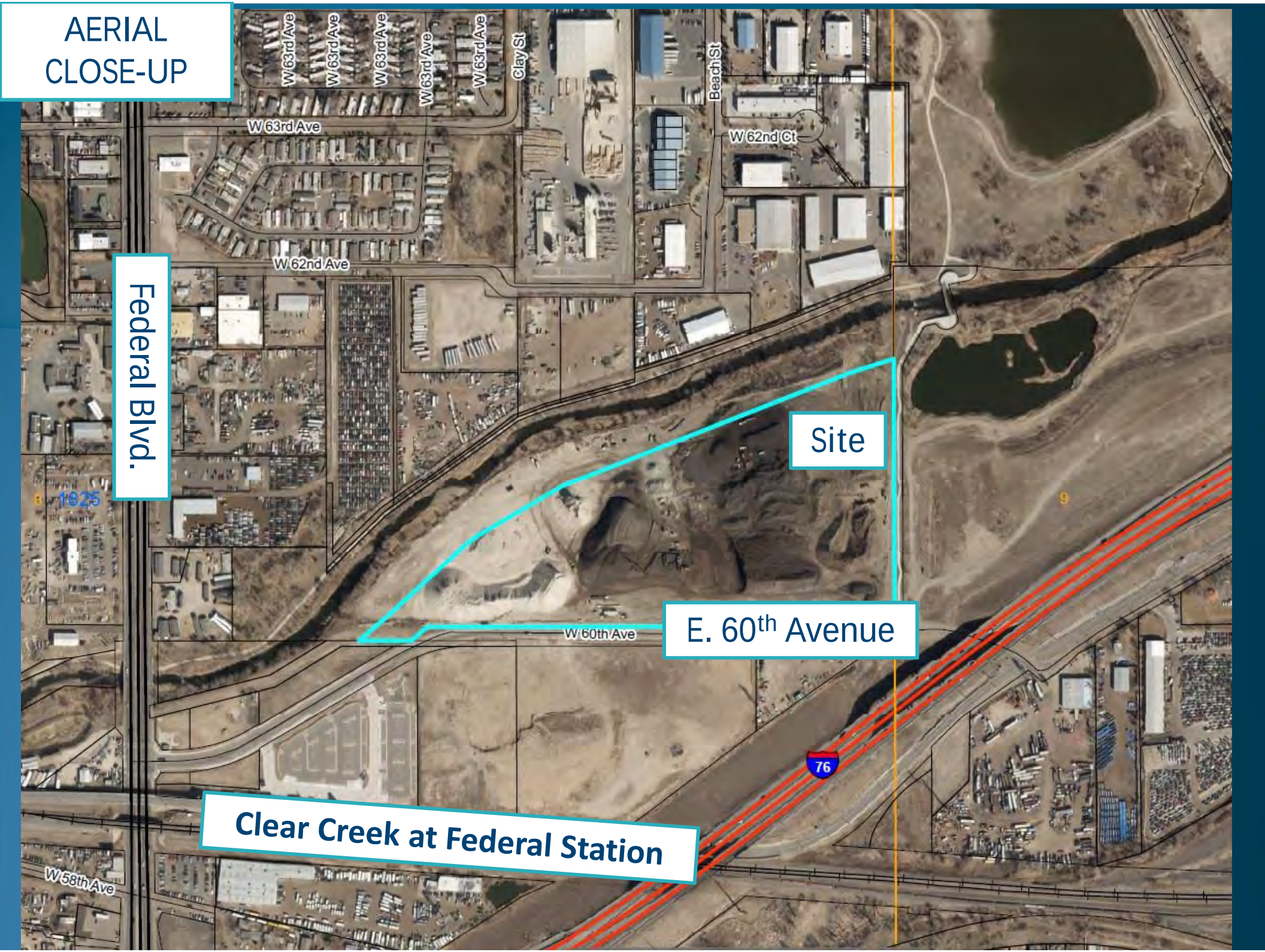
Requests

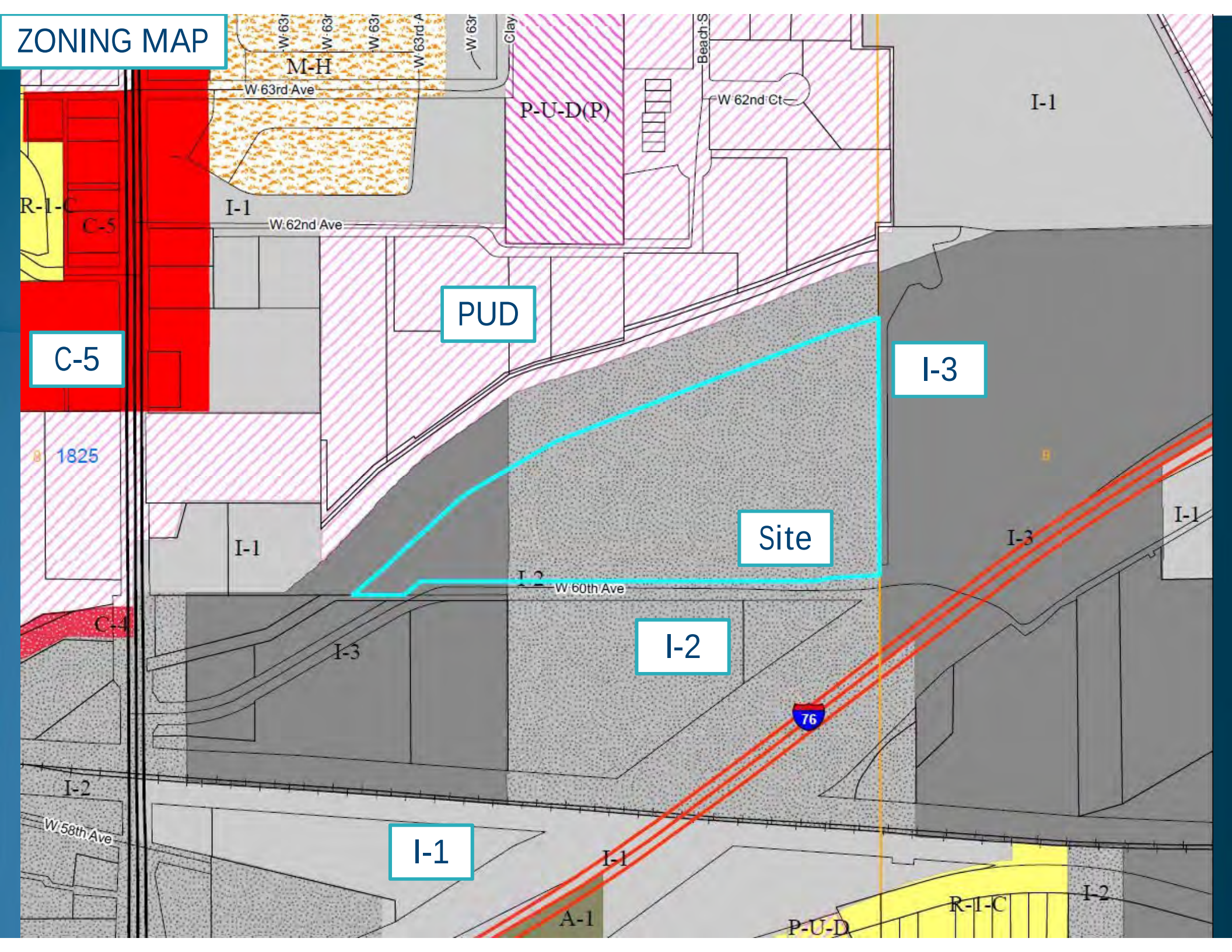
1. Conditional use permit application to allow recycling operations in the Industrial-2 and Industrial-3 zone districts;
2. Conditional use permit application to allow accessory outdoor storage in excess of ten acres in the Industrial-2 and Industrial-3 zone districts;
3. Conditional use permit application to allow stacking of materials up to fifty (50) feet in height and above the height of any screen fencing.

AERIAL OVERVIEW

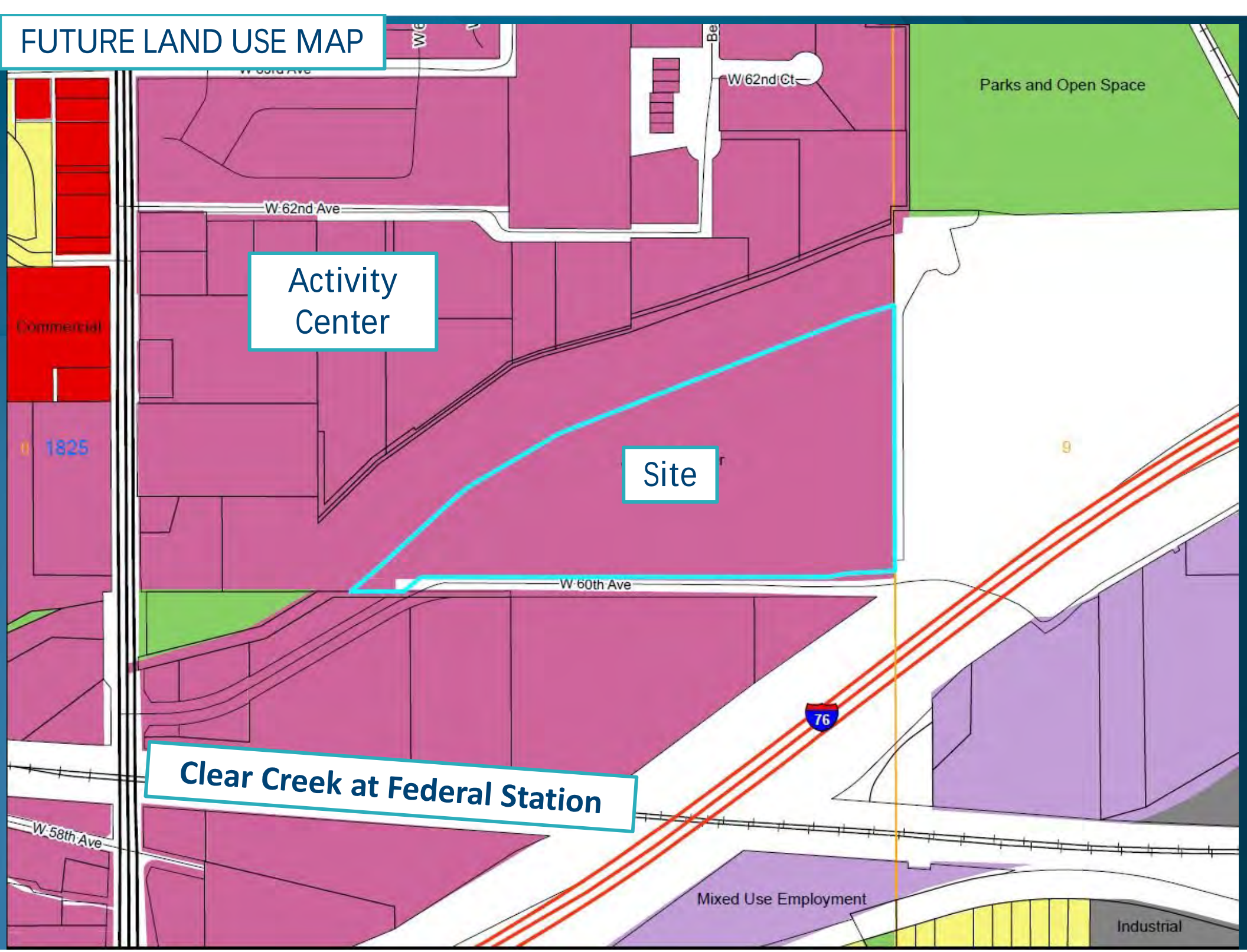


AERIAL CLOSE-UP




ZONING MAP
M-H
W 63rd Ave
P-U-D(P)
W 62nd Ct
I-1
R-1-C
C-5
I-1
W 62nd Ave
PUD
C-5
I-3
1825
I-1
Site
I-3
I-1
W 60th Ave
C-4
I-3
I-2
76
I-2
W 58th Ave
I-1
I-1
A-1
P-U-D
R-1-C
I-2

FUTURE LAND USE MAP



Activity Center

- High-Intensity, Mixed-Use Development
  - Office
  - Hotel
  - High-Density Residential
  - Retail/Restaurant
- Excellent Transportation Access
- High Visibility
- Development in Activity
- Centers must contain a sufficient intensity and mix of uses to create a pedestrian environment and support transit service.
- These centers may be especially suitable for providing a variety of housing or should be planned with due consideration of accessibility between residences and places of employment.

Background

- Use: processing and storage of recycled asphalt material including stockpiling and transport.
- No permits were ever obtained
- October 1995, notice of violation issued by Adams County
  - No permit was obtained

Background

- June 2012, the applicant was granted a conditional use permit at *5880 Lipan Street* for similar use.
  - Condition to require the operations at 2601 W. 60th Avenue to cease and for the site to be vacated by June 2019.
  - July 2020, the applicant has not ceased operations nor vacated the site.
- In May 2017, an inspection of the site was conducted by Adams County, TCHD, and CDPHE.
  - Facility was operating without proper permitting;
  - Outdoor storage that was not associated with the business;
  - 30-foot tall pile of shingles - unpermitted disposal of solid waste and potentially may have included asbestos shingles;
  - Illicit discharge into the Clear Creek;
  - Storage and stockpiling on an adjoining property owned by Adams County.

Background

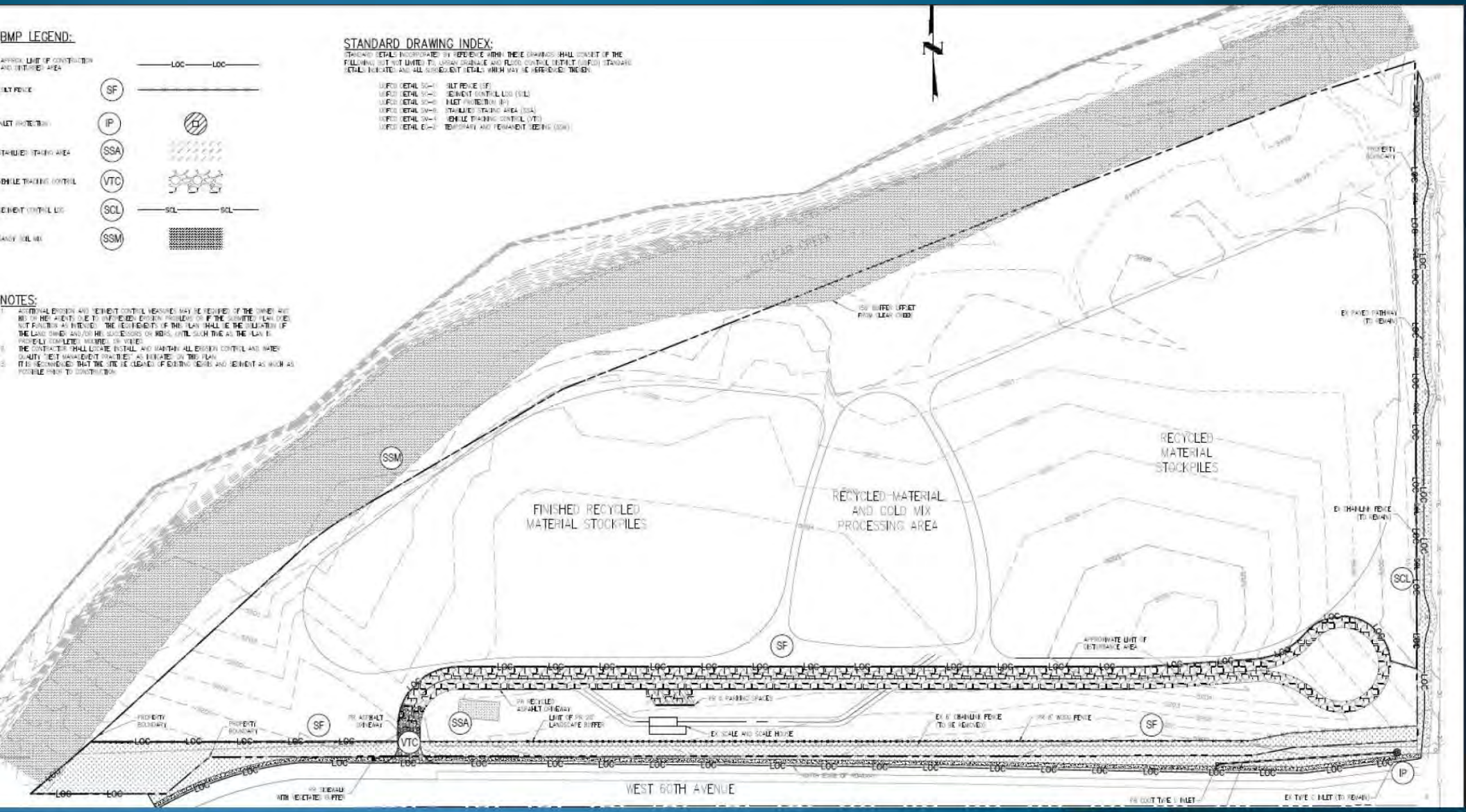
- Post-Inspection
  - Shingles removed
  - Material shifted off adjoining property
- November 2017, Settlement agreement was reached between Brannan Sand & Gravel and Adams County.
  - Timeline for the site to come into compliance
  - Initial compliance for several months
  - February 2018, Extension of deadlines granted
  - June 2019, Full compliance was to be met
  - December 2019, Subject applications filed
  - July 2020, the applicant has not ceased operations nor vacated the site.

Criteria for Conditional Use

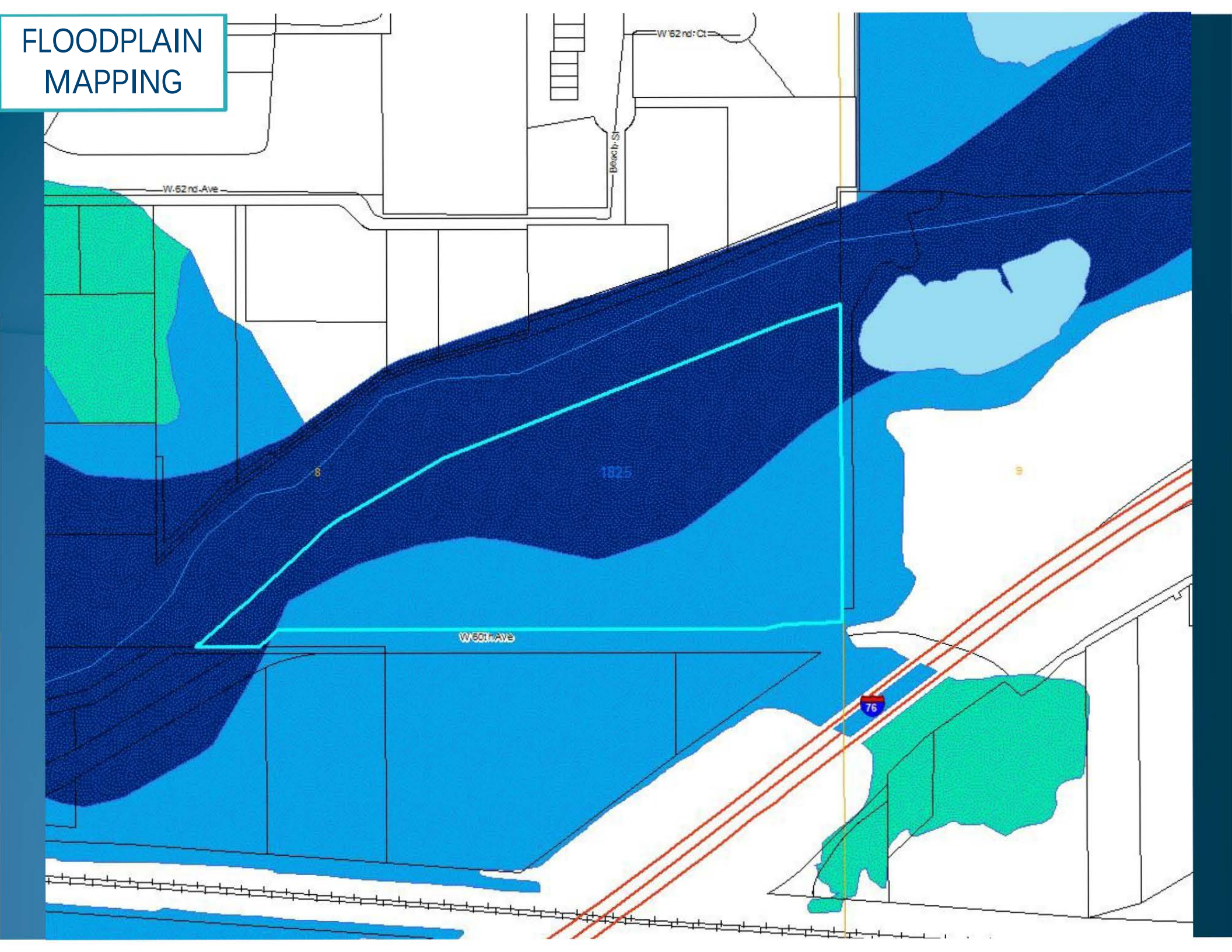
Section 2-02-09-06

1. Permitted in zone district
2. Consistent with purpose of regulations
3. Comply with performance standards
4. Harmonious & compatible
5. Addressed all off-site impacts
6. Site suitable for use
7. Site plan adequate for use
8. Adequate services

SITE PLAN


BMP LEGEND:
LOC
SF
IP
SSA
VTC
SCL
SSM
STANDARD DRAWING INDEX:
NOTES:
FINISHED RECYCLED MATERIAL STOCKPILES
RECYCLED MATERIAL AND COLD MIX PROCESSING AREA
RECYCLED MATERIAL STOCKPILES
EX SCALE AND SCALE HOUSE
EX PAVED PATHWAY (TO REMAIN)
EX CHAINLINK FENCE (TO REMAIN)
EX 6' WOOD FENCE
PROPERTY BOUNDARY
WEST 60TH AVENUE

FLOODPLAIN MAPPING




C


ALL CASH AND
VALUABLES
REMOVED DAILY


Park-n-Ride
Clear Creek
• Federal Station
RTD
2870 W. 60th Ave.

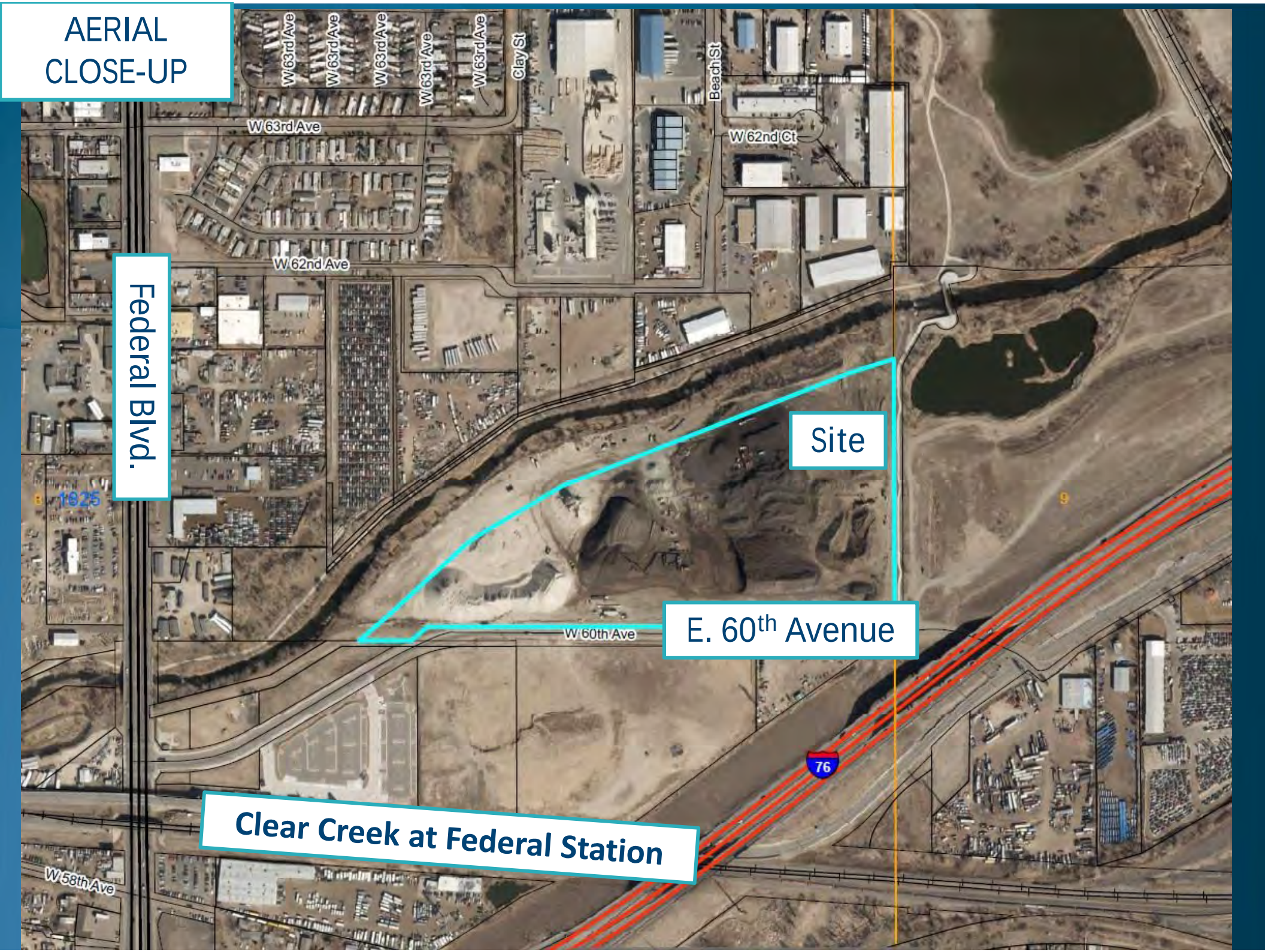
Adams County Comprehensive Planning

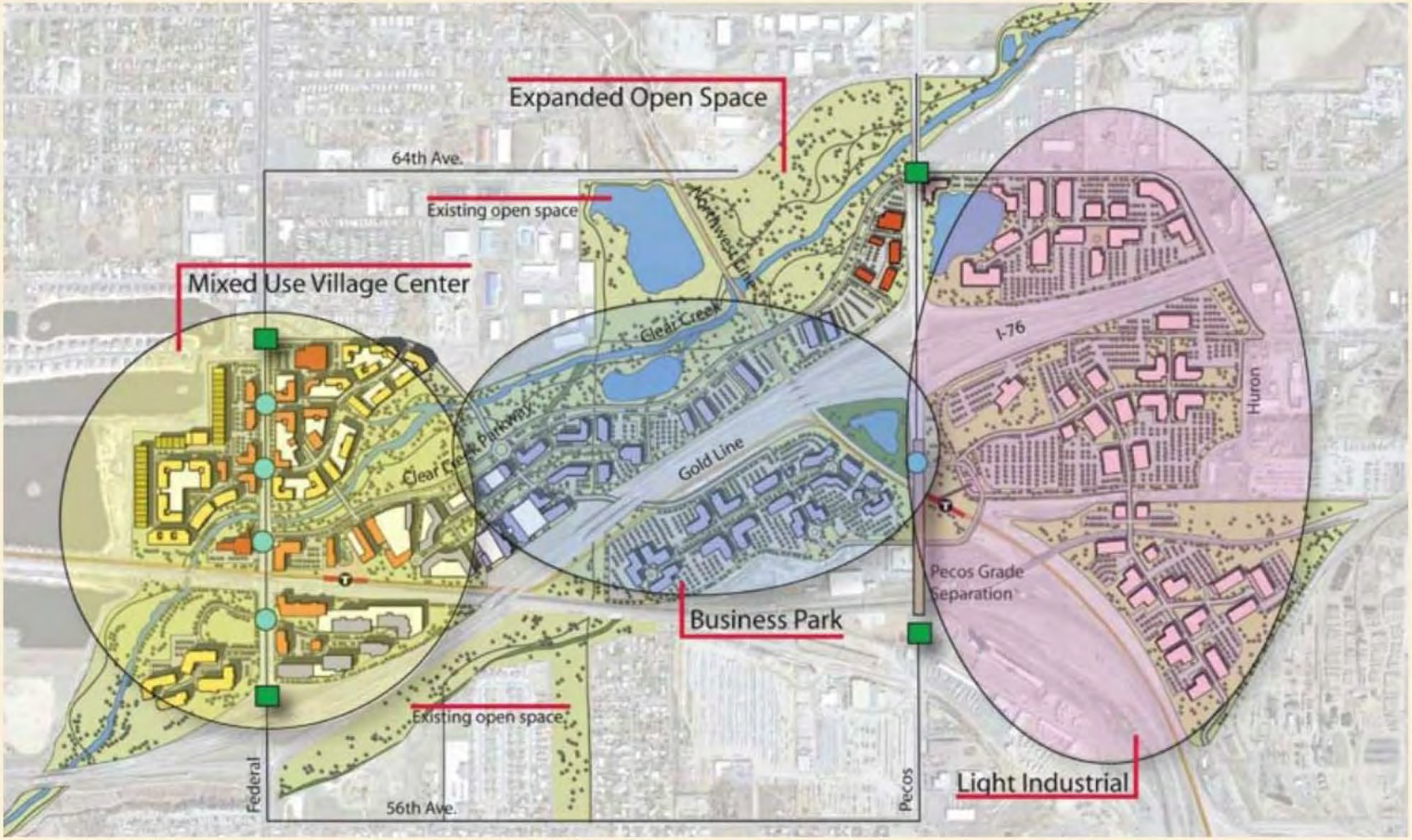
- Southwest Area Plan
  - Policy 14.1 Promote Clean Industrial Uses;
  - Encourage development and redevelopment of a range of industrial uses in the Southwest Area, with emphasis on new clean and/ or light industrial uses
- Federal Boulevard Framework Plan
  - Corridor Planning should address potential Federal Boulevard blight conditions and recommend improvements in visual character. The addition of pedestrian-oriented improvement to the right-of-way is critical in providing better accommodations for non-motorized corridor transportation. Additionally, streetscape planting should be incorporated throughout the corridor with a focus on shade trees along the east and west sides of the roadway due to the utility limitations of the center medians.
  - Corridor planning should address potential methods to land assembly for redevelopment, protection of residential neighborhoods from commercial land use and traffic encroachment, and methods to interconnect the local street grid.
- Clear Creek Valley Transit Oriented Development Plan

Clear Creek Valley Transit Oriented Development Plan, 2009

- Creation of a transit-oriented community
- Pedestrian-oriented to the transit station
- New retail, employment, entertainment and residential opportunities
- Current site designated for Village Center, Business Park, Open Space
- Mixed-use development with sustainable practices
- Open space and recreational opportunities
- Gateway to Southwest Adams County
- Discourages land use patterns in transit corridors and around transit stations that may preclude future Transit Oriented Development
- Discourages land consumptive uses related to heavy industry such as outdoor storage.

AERIAL CLOSE-UP





Retail
Mixed use
Multi family residential
Single family attached

Business/office
Industrial
Structured parking

Signalized intersection (needs CDOT approval)
Gateway

Active street level retail

Interactive corners

Design Standards

Purpose of the Design Standards

The purpose of the Design Standards is to set high quality requirements for design of all projects in the Village Center. Development that is designed to these standards will protect the real estate values in the station area and in the neighborhoods in the vicinity. The standards provide a level playing field for developers which will assure a high standard of design on the part of all participants, and raise the bar for design in the immediate area.

Design Standards for the Village Center

Sustainability

Intent: To achieve sustainable design in developing and building each site promoting integrated design practices that sustain the project economically, environmentally and culturally.

Principles: At a minimum, sustainability within the Village Center shall be measured by the LEED rating system, established by the USGBC. Review and approval of buildings in this area shall be contingent upon the applicant showing progress in obtaining the LEED Certified credits. Affordable housing will be considered as an integral part of planning.

Pedestrian Connectivity

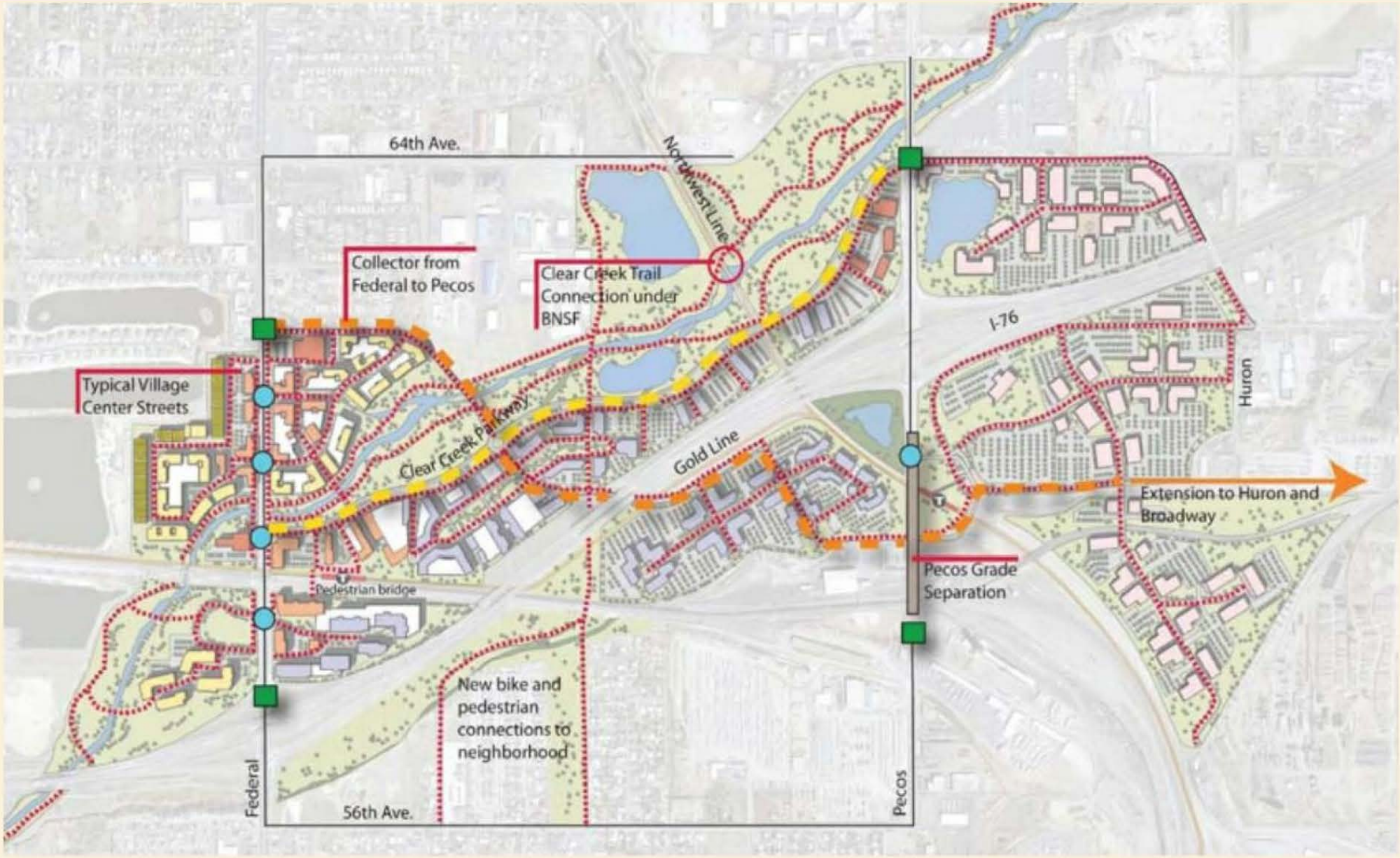
Intent: To connect transit, commercial and housing destinations with convenient, safe and easy to understand pedestrian circulation.

Principles: Walkways, bridges and pedestrian crossings shall constitute a network that interconnects all transit, commercial and residential buildings. Hidden areas and blind corners shall be avoided in favor of open, visible gathering places and unobstructed paths with clear visual connections to destinations beyond. Pedestrian walkways should avoid doubling back or acute changes in the travel path, and should have good visual connection with the surroundings at all times. Active uses should be located along the pedestrian paths.

Ground Floor Activity

Intent: To create a compelling and active pedestrian environment with interesting, accessible activities at the street level.

Principles: Ground floor uses shall consist of active commercial uses, restaurants and entertainment venues in areas that will be frequented by pedestrians. The active space shall be organized in a logical pedestrian flow, without isolating retail activities from public spaces and streets.


64th Ave.
Northwest Line
Collector from Federal to Pecos
Clear Creek Trail Connection under BNSF
I-76
Huron
Typical Village Center Streets
Clear Creek Parkway
Gold Line
Extension to Huron and Broadway
Pedestrian bridge
Pecos Grade Separation
New bike and pedestrian connections to neighborhood
Federal
56th Ave.
Pecos
Clear Creek Parkway
Collector Road from Federal to Pecos
Pedestrian and bike circulation
Signalized intersection (needs CDOT approval)
Gateway

Clear Creek at Federal Station - Mixed-Use Village Center

CLEAR CREEK AT FEDERAL STATION

The vision for the Clear Creek at Federal Station is to create a new vibrant community amenity within walking distance of the transit station. New retail, employment, entertainment and living opportunities within the Village Center will serve the needs of the exisiting community, and maintain the area as an employment center for Adams County.

Parking - 7,230
(Includes station parking at 600 spaces)

Multi-family Residential units - 1,993

Retail - 467,000 SF
Potential jobs - 467 (1/1,000 SF)

Business/office - 398,000 SF
Potential jobs - 1,326 (1/300 SF)

Open Space - 66 acres

Progam based on hypothetical assumptions of maximum buildout. Not based on current zoning or entitlements.

Retail
Mixed use
Multi family residential
Single family attached
Business/office
Structured parking
Signalized intersection (needs CDOT approval)
Gateway

Comments on Case

Referral agency comments:

- Colorado Division of Water Resources (No concerns)
- Colorado Department of Transportation (No concerns)
- City of Arvada (No Concerns)
- Denver Water (No concerns)
- Adams County Fire (No concerns)
- Regional Transportation District (No comments)
- Tri-County Health Dept. (Concerns – fugitive dust, historic landfill)
- Xcel Energy (No concerns)

Public comments:

Property owners and residents within 1,500 feet

Notifications Sent	Comments Received
162	2

Summary

The determination by staff is that the request is inconsistent with the criteria for approval:

- The conditional use is incompatible with the surrounding area
- The conditional use is not harmonious with the character of the neighborhood
- The conditional use is detrimental future development of the area
- The conditional use , and detrimental to the health, safety, or welfare of the inhabitants of the area and the County
- The request cannot address all off-site impacts
- Character of the neighborhood is changing
- History of noncompliance with County standards

Planning Commission Update

Public Hearing: July 9, 2020

No public comments provided at hearing

PC Questions/Concerns:

- Long-Range Plans
- Off-Site Impacts
- History of Noncompliance

Voted 5-0 for Denial

Previous Board of County Commissioners Hearing

Public Hearings : July 28, 2020 & August 11, 2020

Applicant requested continuance of the case at both hearings

Suggested that more time was needed to find a mutually beneficial solution

Since the last continuance, staff has not been contacted by the applicant

Voted 4-0 for Continuance

Recommendation

Denial of Conditional Use Permit (PRC2019-00020) based on:

- 14 Findings-of-Fact

Findings-of-Fact

8. The request for outdoor storage is incompatible with the Adams County Comprehensive Plan, does not comply with the minimum zoning requirements of the zone district in which the Conditional Use Permit is to be granted, and does not comply with all other applicable requirements of the Adams County Development Standards and Regulations.
9. Aesthetic concerns have not been taken into consideration during the site design and placement of the outdoor storage.
10. The request for a recycling facility is incompatible with the Adams County Comprehensive Plan, does not comply with the minimum zoning requirements of the zone district in which the Conditional Use Permit is to be granted, and does not comply with all other applicable requirements of the Adams County Zoning and Subdivision Regulations.
11. The applicant has not documented his ability to comply with the health standards and operating procedures as provided by the Colorado Department of Public Health and Environment, Tri-County Health Department, Fire District, and other relevant agencies.
12. The proposed facility will cause significant traffic congestion or traffic hazards.
13. The request is incompatible with the surrounding area.
14. The site will impact health and welfare of the community based upon specific recycling facility design and operating procedures.

Findings-of-Fact

1. The conditional use is not permitted in the applicable zone district.
2. The conditional use is inconsistent with the purposes of these standards and regulations.
3. The conditional use will not comply with the requirements of these standards and regulations, including but not limited to, all applicable performance standards.
4. The conditional use is incompatible with the surrounding area, not harmonious with the character of the neighborhood, detrimental to the immediate area, detrimental to the future development of the area, and detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
5. The conditional use permit has not addressed all off-site impacts.
6. The site is unsuitable for the proposed conditional use including adequate usable space, adequate access, and absence of environmental constraints.
7. The site plan for the proposed conditional use will not provide the most convenient and functional use of the lot including the parking scheme, traffic circulation, open space, fencing, screening, landscaping, signage, and lighting.

Additional Staff Review Possible

If considering approval of the use:

- Improved Landscape Plan
- Reduced Stacking Heights
- Higher-Quality Fencing
- Improved Environmental Controls
- Limited Duration

Alternative Recommendation

Continuance of the case to September 22, 2020 agenda

Allows more time for staff and the applicant to collaborate on an improved site plan to better mitigate off-site impacts of the use.