

NOTICE:

THE SWEETWATER COUNTY BOARD OF COUNTY COMMISSIONERS WILL MEET ON TUESDAY, JULY 21, 2026 AT 9:00 A.M. - TENTATIVE AND SUBJECT TO CHANGE

**The meeting will be held at the 80 West Flaming Gorge Way
Meeting Room #115
Green River, Wyoming 82935.**

For the convenience of the public, the Board of County Commissioners' meeting will be held in person and using video conferencing.

Those presenting may appear in person or via Zoom using the meeting invite received by email.

As always, the public is invited to watch the proceedings on the County YouTube channel <https://www.youtube.com/c/SweetwaterCountyGovernment> where the meeting will be broadcast.

The public will be able to comment immediately following the public hearing presentation and also during the public comment section of the agenda.

If you are in need of accommodations beyond the above identified process, please call in advance to discuss other options. If you have any questions about how to participate in a public Board of County Commissioners meeting, please contact Sally Shoemaker at 307-872-3897 or via email at shoemakers@sweetwatercountywy.gov

PRELIMINARY:

PLEDGE OF ALLEGIANCE

ROLL CALL / QUORUM PRESENT

APPROVAL OF THE AGENDA

A. PUBLIC HEARING

1. [Amendments to Oversize and Overweight Vehicle Regulations--Resolution 2026-07-CC-04](#)
Undersheriff Joe Tomich

B. PUBLIC HEARING - PLANNING AND ZONING

1. [26-07-ZO-01 A Zoning Map Amendment for approximately 320 acres more or less to be amended from Agriculture \(A\) and Mineral Development \(MD-1\) to add a Mineral Development \(MD-2\) Overlay](#)
Kassidee Brown, Planner
2. [26-07-ZO -02 A Zoning Map Amendment for approximately 160 acres more or less to be amended from Agriculture \(A\) to add a Mineral Development \(MD-2\) Overlay](#)
Kassidee Brown, Planner

9:35- COUNTY RESIDENT COMMENTS/CONCERNS

All members of the public who wish to speak at the meeting will be given 3 minutes of time to address the Commission.

C. 9:45- CONSENT AGENDA

All matters listed on the consent agenda are taken in one motion and one vote. Items pulled from the consent agenda will be discussed and voted on separately.

1. [Approval of the June 30, 2026 Minutes](#)
BOCC
2. [Approval of the July 7, 2026 Minutes](#)
BOCC
3. [Approval of County Vouchers/Warrants Expenditure Approval Listing \(EAL\) and Commissioner Report](#)
Accounting
4. [Approval of the Bonds](#)
BOCC
5. [Approval of the Monthly Reports](#)
BOCC
6. [Approval of Abates-Rebates](#)
Joe Sanchez, Lead Appraisal Technician, Assessor

COMMISSIONER COMMENTS

9:50- Chairman West
Keaton West

9:55- Commissioner Slaughter
Robb Slaughter

10:00- Commissioner Thoman
Mary Thoman

10:05- Commissioner Richards
Island Richards

10:10- Commissioner Jones
Taylor Jones

D. ACTION/PRESENTATION ITEMS

1. [10:15- Solid Waste Disposal District- Eden Valley Board Appointment](#)
BOCC

2. 10:20- Acceptance of the FY 2027 Services to Victims of Crime Grant Contract
County Grants Manager Krisena Marchal
3. 10:25- Approval to Submit a FY 2027 CMAQ Grant Application
County Grants Manager Krisena Marchal; Assistance Public Works Director Andy Hooten
4. 10:30- Change Order #1 for Time to the Green River Courthouse Elevator Modernization Project
Gene Legerski, Public Works Director
5. 10:35- Real Property Lease No. 8-09831 Between Sweetwater County and State of Wyoming, Department of Administration and Information, General Services Division
Gene Legerski, Sweetwater County Public Works Director and John DeLeon, Sweetwater County Chief Deputy County Attorney
6. 10:40- Request to add the auto excess coverage to the Summary Plan Description, effective January 1, 2026
Garry McLean, Sweetwater County HR Director

ADJOURN

Per Wyo. Stat. §18-3-516(f) County information can be accessed on the County's website at www.sweetwatercountywy.gov

The draft packet will be available on the county website on Friday afternoon (prior to the meeting).



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: tomichj@sweetwatercountywy.gov; 307-922-5295
Presenters Name, Title and Name of Organization: Undersheriff Joe Tomich	Exact Wording for Agenda: Amendments to Oversize and Overweight Vehicle Regulations--Resolution 2026-07-CC-04
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 10 minutes for public hearing.	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information: This resolution will amend Sections 4, 5, 6, 15, and 16 of the Regulation of the Size and Weight of Vehicles and Loads on County Roads Within Sweetwater County to alleviate undue burden on the transportation industry within Sweetwater County. A copy of the proposed amended language is attached.	
Attachments: Oversize Permit Amendment Resolution 07-26.docx Oversize-Overweight Amendments June 2026.pdf Opposition Letter to Proposed Amendments to Sweetwater County Rules and Regulations (Resolution 2026-03-CC-02).pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov

*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****

- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item may be rescheduled.
- In order to determine placement on the agenda, please review the county website sweetwatercountywy.gov on Thursday afternoon by clicking “Commissioner's Agenda”.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[Oversize Permit Amendment Resolution 07-26.docx](#)

[Oversize-Overweight Amendments June 2026.pdf](#)

[Opposition Letter to Proposed Amendments to Sweetwater County Rules and Regulations \(Resolution 2026-03-CC-02\).pdf](#)

RESOLUTION 2026-07-CC-04

AMENDMENTS TO REGULATION OF THE SIZE AND WEIGHT OF VEHICLES AND LOADS ON COUNTY ROADS WITHIN SWEETWATER COUNTY RESOLUTION SECTION 4 (PERMIT TYPES), SECTION 5, STATUTORY AND ADMINISTRATIVE EXEMPTIONS), SECTION 6 (PERMIT FEES), SECTION 15 (PRE-PURCHASED PERMIT PROCEDURES), AND SECTION 16 (PROCEDURE FOR OBTAINING CLASSES OF PERMITS)

WHEREAS, on May 28, 2026 the Sweetwater County Board of County Commissioners advertised that a public hearing would be held on July 21, 2026 at 9:00 a.m. proposing amendments to Section 4 (Permit Types), Section 5 (Statutory and Administrative Exemptions), Section 6 (Permit Fees), Section 15 (Pre-Purchased Permit Procedures), and Section 16 (Procedure for Obtaining Classes of Permits) of the Regulation of Size and Weight of Vehicles and Loads on County Roads Within Sweetwater County and Establishing a Permitting Process for Oversize and Overweight Vehicles and Loads, and;

WHEREAS, on May 28, 2026 the Sweetwater County Board of County Commissioners advertised the opportunity to provide written public comment and input for the proposed amendments prior to July 17, 2026, and;

WHEREAS, on June 2, 2026 the Sweetwater County Board of County Commissioners voted 5-0 to sign and did sign a Notice of Intent to consider adoption of the amendments to the Regulation of Size and Weight of Vehicles and Loads on County Roads Within Sweetwater County and Establishing a Permitting Process for Oversize and Overweight Vehicles and Loads, and;

WHEREAS, this Notice of Intent called for public comments to be received before July 17, 2026 and that the Sweetwater County Board of County Commissioners would consider adoption of these new rules after a public hearing on July 21, 2026 notice of which was advertised on May 28, 2026 and June 4, 2026.

NOW THEREFORE, the Sweetwater County Board of County Commissioners ADOPTS the Amendments to Section 4 (Permit Types), Section 5 (Statutory and Administrative Exemptions), Section 6 (Permit Fees), Section 15 (Pre-Purchased Permit Procedures), and Section 16 (Procedure for Obtaining Classes of Permits) of the Regulation of Size and Weight of Vehicles and Loads on County Roads Within Sweetwater County revised June 2026.

Dated this 21st day of July, 2026.

Sweetwater County
Board of County Commissioners

Keaton D. West, Chairman

Taylor C. Jones, Member

Island Richards, Member

Attest:

Robert D. Slaughter, Member

Cynthia L. Swenson, County Clerk

Mary Thoman, Member

Section 4: Permit-Issuing Authorities and Types of Permits Available

Subject to the conditions in these rules and regulations, the following are authorized to issue permits for moving non-divisible oversize and/or overweight loads and vehicles:

- (a) The Sweetwater County Sheriff and/or his authorized representatives;
- (b) The Sweetwater County Director of Public Works and/or his authorized representatives.

For uniformity and simplicity, the Sweetwater County Government adopts and recognizes the following classes of permits as defined, regulated, and issued by the Wyoming Department of Transportation, Wyoming Highway Patrol, and their authorized representatives.

- (a) **Class A permits (Super Loads)** authorize separate movements of non-divisible loads exceeding Class B or Class C limits. Class A permits shall be approved ONLY by the Overweight Loads Office and are issued by permit-issuing authorities. Loads more than 18 feet wide or high require a minimum of 24-hour prior notification by the carrier. Movements that are delayed shall notify the Overweight Loads Office. Class A permits are subject to any conditions or restrictions imposed.
- (b) **Class B permits** authorize separate movements of non-divisible loads not exceeding Class B limits. Annual Class B permits may be issued, allowing unlimited number of movements of loads not exceeding Class B limits.
- (c) **Class C permits** are self-issuing permits that authorize separate movements of non-divisible loads not exceeding Class C limits. The Overweight Loads Office approves and issues Class C permits to qualified residents of Wyoming. The self-issuing permit holder shall complete a separate Class C permit before each separate move.
- (d) **Class D permits** are extended period permits authorizing multiple movements of vehicles without loads or with a non-divisible load or vehicle that does not exceed the Class D limits. Class D permits are approved for specified vehicles and loads, routes, and time periods.
- (e) **Class E permits** are oversize permits for separate movements or extended periods of movement. Class E permits are effective for one or more months (not to exceed 90 days) to permit hauling forest products, baled hay or corn stalks, or combine headers.
- (f) **Class F permits** are overweight permits for separate movements or extended periods of movement. Class F permits are effective for one or more months (not to exceed 90 days) to permit hauling of forest products, sugar beets, gravel, livestock, and agricultural products in trucks that cannot be weighed at the point of loading on primary and secondary highways ONLY.
- (g) **Class W permits** are for multi-piece loads exceeding 117,000 pounds on primary and secondary highways ONLY.

~~(g)~~(h) **Off-load permits** are for vehicles or loads exceeding statutory size and/or weight limits that cannot be safely reduced at the location where the violation was discovered. (Please see W.S. 31-18-805[b].) These permits shall not exceed Class B limits without the Overweight Loads Office authority. Off-load permits shall be issued as explained in Section 5, "Statutory and Administrative Exemptions".

~~(h)~~(i) **Secondary tow permits for weight** shall be issued as explained in the WYDOT rules and regulations for Motor Carriers, Section 5, "Statutory and Administrative Exemptions".

~~(i)~~(j) **Emergency relief permits** are oversize and/or overweight permits for separate movements or extended periods of movement. Emergency relief permits are issued when the Governor or the director has determined that greater vehicle weight or size will relieve an economic hardship or benefit the general welfare of the state of Wyoming or another state. Emergency relief permits shall be issued as explained in the WYDOT rules and regulations for Motor Carriers, Section 24.

~~(j)~~(k) **Prior operation permits** are issued for unauthorized, non-permitted, and/or size and weight violations for exceeding statutory or permit limits.

Sweetwater County requires a county **Class A Permit** for operation of vehicles and/or vehicles with loads on county roads exceeding Class B or Class C limits. These moves must be approved and issued by permit issuing authorities as listed in Section 4. These super load permits ~~may shall~~ require seven (7) calendar days' notice be given and are subject to all restrictions imposed by ~~either the Sweetwater County Road and Bridge Public Works Department or Sweetwater County Sheriff's Office.~~

Sweetwater County requires county **Class B, C and D permits** for operation of vehicles and/or vehicles with loads on county roads exceeding statutory size or weight limits but within Class B, Class C or Class D permitting limits.

In addition to these permits Sweetwater County has created **Rig Move Permits, designated as a Class R permit**, which are an extended period permit valid for not more than a 5-day period and are valid on all non-restricted Sweetwater County County roads, allowing for the movement of up to ~~eighty (80)~~**forty-five (45)** oversize and/or overweight loads not exceeding Class B/C limits and five (5) Class A loads. These permits are valid for the movement of the rig and supporting components, not including the movement of oversize and/or overweight equipment facilitating the move but not a part of the rig. All loads must comply with oversize and overweight rules, safety regulations, and permit class maximums. Rig move permits are an alternative to individual load permits and will be issued when requested 72 hours prior to the rig move.

Sweetwater County will recognize the following "in-hand" permits issued by WYDOT, WHP, and their authorized representatives, as valid for movement on county roads without a county permit:

- (a) Class E permits issued for the separate movements or extended periods of movement effective for one (1) or more months, not to exceed ninety (90) days, permitting the hauling of forest products, baled hay or combine headers. Forest products exceeding one hundred twelve (112) inches in width or any load of baled hay or combine headers exceeding one hundred fifty (150) inches in width and fifteen (15) feet in height or loads having a single component exceeding one hundred two (102) inches in width, will not be permitted.
- (b) The commercial movement of one (1) or more motor homes, house trailers or truck campers that exceed the maximum width authorized under W.S. 31-18-802(a)(i)(A).
- (c) Secondary tow permits;
- (d) Emergency relief permits; and
- (e) Sweetwater County requires a county Class F, Class W, and Off-load permit be issued in conjunction with a for Class F, Class W, and Off-load permit issued by WYDOT, WHP and their authorized representatives.

Classes B, C, or D permit limits shall not exceed the following:

MEASUREMENT CLASS B AND CLASS C LIMITS CLASS D LIMITS

Width	18 feet	12 feet	
Height	17 feet	15 feet	
Length:	Single unit or part of a combination	not applicable	75 feet
	Overall vehicle or combination	120 feet	120 feet
Weight:	Single axle	25,000 pounds	25,000 pounds
	Single axle when included in a tandem axle	29,000 pounds	29,000 pounds
	Tandem axle	55,000 pounds	55,000 pounds
	Triple axle	65,000 pounds	65,000 pounds

All other axle groups are governed by the number of axles and axle measurements. (See maximum allowable table at the end of this section):

Gross Weight	160,000 pounds	160,000 pounds
Single axle with construction or off-		

<u>MEASUREMENT</u>		<u>CLASS B & C LIMITS</u>	<u>CLASS D LIMITS</u>
Width;	-	18	12
Height;	-	17	15
Length	Single unit or part not applicable of a combination	N/A	75 feet
	Overall vehicle or combination	120 feet	120 feet
Weight;	Single axle	25,000 pounds	25,000 pounds
	Single axle when included in a tandem axle	29,000 pounds	29,000 pounds
	Tandem axle	55,000 pounds	55,000 pounds
	Triple axle	65,000 pounds	65,000 pounds
All other axle groups are governed by the number of axles and axle measurements. (See maximum allowable weight table at the end of this section).			
	Gross Weight	160,000 pounds	160,000 pounds
	Single axle with construction or off-road machinery tire	50,000 pounds	55,000 pounds

Variable Load Suspension Axle: If any axle group containing a variable load suspension axle exceeds legal or allowable weight without using the variable load suspension axle, the variable load suspension axle shall be used to the extent that it assumes sufficient weight to keep the axle group with which it is used within legal weight for a divisible load or permissible weight for a non-divisible load.

Vehicles equipped with a functional variable load suspension axle shall be required to put the axle into use if the vehicle is overweight and the use of the axle will reduce the amount of overweight on an axle group, inner bridge, or gross. In certain cases, the use of this type of axle may reduce the allowable weights a vehicle may carry. If the allowable weight is reduced due to decreased bridge between axle groups, the use of the axle is not required.

Non-divisible loads as defined in Section 2, "Definitions", number 39 of these rules and regulations shall be governed according to the following:

Weight: For single units it shall be permissible to issue a permit to an overweight vehicle pulling a trailer, as long as the trailer does not transmit more than 500 pounds tongue weight onto the overweight vehicle and/or does not result in a greater overage than the single unit by itself. Carriers using this configuration shall use Weight Table 1. If possible, all overweight loads shall be arranged to equalize the weight approximately between axle groups.

Oversize: When an oversize load includes 2 or more items hauled along with a one-piece oversize item that has been permitted for its oversize, the 2 or more pieces shall be allowed if the entire load is being transported or hauled on the same vehicle or trailer,

- (c) Implements and produce of husbandry. *(Please see WYDOT Rules and Regulations for Motor Carriers, Chapter 5, Section 21, "Implements and Produce of Husbandry Moved by Farmers and Ranchers", and Section 22, "Implement Dealers".)*
- (d) Forest products, gravel, and agricultural products that cannot be weighed at the point of loading on primary and secondary highways ONLY (Class E and Class F Permits.)
- (e) Permits for multi-piece divisible loads exceeding 117,000 pounds on primary and secondary highways ONLY. (Class W Permits.)
- (f) Non-commercial motor homes, house trailers, and truck campers in compliance with W.S. 31-18-802(a)(i)(A). *(Please see WYDOT Rules and Regulations for Motor Carriers, Chapter 5, Section 18, "Moves of Recreation Vehicles".)*
- (g) Off-load permits may be issued in special circumstances if a permit-issuing authority determines that a vehicle or load exceeding statutory limits cannot safely be reduced at the location where the violation was discovered. These permits authorize separate movements of divisible loads not exceeding Class B limits to the nearest location (figured by determining the least number of miles traveled on any highway) for reduction in size and/or weight. If it is determined that carriers are abusing this permit, the load shall be reduced at the violation location or returned to point of loading; regardless of the cost or inconvenience to the carrier.
- (h) For an over-the-road bus, public transit bus, or motor home, the weight limit on a single axle is increased to 24,000 pounds on interstate highways ONLY. As used in this paragraph, "motor home" means a multipurpose passenger vehicle with motive power that is designed to provide temporary residential accommodations, as evidenced by the presence of at least four of the following facilities: cooking, refrigeration or ice box, self-contained toilet, heating and/or air conditioning, a potable water supply system including a faucet and a sink, and a separate 100–125-volt electrical power supply, and/or propane.
- (h)(i) Loads in excess of the statutory limit while travelling immediately to or from the nearest safe parking location during the closure of a state highway or interstate which the load was previously operating upon. Operator shall notify the Sweetwater County Sheriff's Office to confirm routing prior to movement. Crossing of bridges are not included in this exemption.
- (j) Class B, C, D, E, or F oversize or overweight loads and Class A oversize loads travelling less than five (5) miles on a Sweetwater County Road while travelling on the shortest path

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to the nearest state highway or city street shall not be required to obtain a permit prior to operating on the following Sweetwater County Roads:

- i. Yellowstone Road (County Road 58)
- ii. JY Road (County Road 88)
- iii. Reliance Road (County Road 42)
- iv. Winton Road (County Road 66)
- v. Wamsutter Crooks Gap Road (County Road 23)
- vi. Blairtown Road (County Road 51)
- vii. Lagoon Road (County Road 112)
- viii. Layos Drive (County Road 1243)
- ix. Landfill Road (County Road 64)
- x. McKinnon Road (County Road 1) north from the intersection of Wyoming Highway 414
- xi. All County Roads within the Northpark/North Rock Springs Subdivision between Signal Drive and Villa Lane
- (+)xii. All County Roads within the Bureau of Reclamation Eden Valley Irrigation Project

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Section 6: Permit Fees

- (a) **County class A permit fees** for oversize loads shall be \$60.00 for any vehicle or load exceeding Class B and Class C limits.
- (b) **County class A, Prior-operation, and off-load permit fees** for overweight loads shall be \$50.00 for any vehicle or load exceeding class B limits, plus \$1.25 per ton over Class B limits, per mile, traveled on county roads.
- (c) **Loads exceeding 80 tons (160,000 pounds)** shall require a minimum fee of \$85.00 for analysis of structure, and roadway capabilities to withstand the load before the permit is issued. Costs in excess of the minimum fee incurred by Sweetwater County to process the permit will be billed. These costs shall include personnel time at \$75.00 per hour plus amounts spent analyzing routes. Time will also be billed for all Sweetwater County personnel deemed necessary to accompany the movement.
- (d) **County class B, C, Prior-operation, and off-load permit fees** for oversize loads shall be \$30.00 for any vehicle or load exceeding the statutory limits but within Class B and Class C limits.
- (e) **County class B, C, Prior-operation, and off-load permit fees** for overweight loads shall be \$50.00 for any vehicle or load exceeding the statutory limits but within Class B and Class C limits.

(f) County class B annual permit fees for oversize loads shall be \$900 for any vehicle or load exceeding the statutory limits but within Class B limits, and the term of the permit shall not exceed one calendar year from the date of issue.

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(e)(g) County class B annual permit fees for overweight loads shall be \$1,500 for any vehicle or load exceeding the statutory limits but within Class B limits, and the term of the permit shall not exceed one calendar year from the date of issue.

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(f)(h) County class D extended period permit fees for multiple movements of oversize vehicles without a load and not exceeding class D size limits shall be \$60.00.

(g)(i) County class D extended period permit fees for multiple movements of overweight vehicles or vehicles with a load, and not exceeding class D weight limits shall be \$500.00.

(h)(j) County class F permit fees are \$20.00 for a single trip permit and \$55.00 for an extended period not to exceed ninety (90) continuous days. A county class F will only be issued in conjunction with, and for the same time period as, a class F permit issued by the Wyoming Department of Transportation.

(i)(k) County class W permit fee is \$500.00 and is only issued in conjunction with a class W permit issued by the Wyoming Department of Transportation. The county permit is valid for the same period of time as the Wyoming Department of Transportation permit.

(l) County class R (Rig Move Permit) fee is \$53,000.00 when issued upon appropriate request to move a rig on Sweetwater County County Roads. Rig move permits are valid for a period not to exceed 5 days. This fee may also be applied to the primary contract carrier of a rig move found to have been relocated using Sweetwater County County Roads without first having obtained valid county permits.

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Section 7: Permitted Hours and Dates of Movement; Weather Conditions

(a) **Hours.** The movement of any oversize load or vehicle shall be made only during daylight hours, except for the following:

- i. With permission of the Sweetwater County Sheriff or his designee.
- ii. A single unit as part of a combination exceeding 60 feet in length, properly permitted, signed and lighted as required in Section 8, "Safety Measures and

Moves,” provided the overall length of the combination does not exceed 100 feet; or a single unit alone exceeding 60 feet in length, properly permitted, signed and lighted as required in Section 8 provided the total length of the single unit does not exceed 75 feet.

- iii. A vehicle or load up to 10 feet wide properly permitted and equipped for nighttime interstate moves and going to a destination within 5 miles from the interstate.
 - iv. A vehicle or load properly permitted, signed, and lighted as required by the WYDOT Rules and Regulations for Motor Carriers, Chapter 5, a vehicle or load responding to the location of an emergency or train derailment.
 - v. Permit issuing authorities may restrict movements to daylight hours of minimum traffic volume. These hours may be stipulated as a condition of the permit.
 - vi. Overweight movements meeting legal size requirements are allowed to move with a permit. These vehicles are not limited to operating during daylight hours.
- (b) Single trip permits shall be issued for a reasonable amount of time to complete the move, not to exceed four (4) days.
- (c) Oversize movements requiring escorts whose route also includes state highways shall not be allowed on legal holidays or during local celebrations when heavy local traffic is anticipated. Legal holidays when travel shall be restricted are the following:
- i. New Year’s Day (January 1)
 - ii. Martin Luther King Day (January)
 - iii. Presidents’ Day (third Monday in February)
 - iv. Good Friday (1/2 day)
 - v. Memorial Day (Last Monday in May)
 - vi. Independence Day (July 4)
 - vii. Labor Day (First Monday in September)
 - viii. Veterans’ Day (November 11)
 - ix. Thanksgiving Day and the Friday following (Fourth Thursday and Friday in November)
 - x. Christmas (December 25)
- ~~xi.~~
- (d) Any other holidays, as proclaimed by the Board Moves requiring escorts shall not be permitted to travel from one-half hour after sunset the evening before a holiday until one-half hour before sunrise the day after the holiday. When a holiday is combined with a weekend for a 3-day weekend, these restrictions shall be in force from one-half hour after

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4. "Permit-issuing Authorities and Types of Permits Available" for a period not to exceed one (1) calendar year from date of purchase.

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~~(a)~~(b) County Class C (pre-purchased) permits are issued to operators of oversize or overweight loads on county roads. These permits authorize separate movements of non-divisible loads that do not exceed the Class C limits indicated in Section 4, "Permit-issuing Authorities and Types of Permits Available."

~~(b)~~(c) **Application and Accountability** – County Class B Annual and Class C permits will be issued to companies requesting them only after:

- (i) Completing the prescribed application for pre-purchased county permits.
- (ii) Providing proof of authority to operate in Wyoming as a commercial carrier.

~~(iii) Attending a pre-purchased permitting class administered by the Sweetwater County Sheriff's Office.~~

~~(iv)~~(iii) Paying the established fee for the number of permits issued.

~~(v)~~(iv) Having accounted for any permits currently held.

(c) Restrictions on Use

- (i) County Class C permits are valid for single separate movements only when it is not feasible to obtain a Class B permit prior to load movement due to lack of network service preventing access to the electronic permit system or other identified hardship approved by the County.
- (ii) The route of the proposed movement shall be checked for obstacles or restrictions prior to completing the self-issue permit.
- (iii) The vehicle and load size and weight must be within the permitting limits for Class C permits as specified in Section 4, "Permit-issuing Authorities and Types of Permits Available."
- (iv) Be issued only to vehicles owned or leased by them. Class C permits shall not be issued to other individuals or companies.

(d) Completion and Disposition of County Class C and R Permits

- (i) County Class C permits are separate for oversize and overweight. Movements which are both oversize and overweight must be issued both permits. The permit(s) shall be fully completed before the movement begins. The original(s) shall be carried in the vehicle to which they refer and shall be displayed to any permit issuing authority or law enforcement upon demand. A digital copy of the original permit, sent electronically before the move began, will be accepted.
- (ii) The dates of movement listed on the permit shall only be for the date(s) reasonably necessary to complete the move. Permission to extend a permit may be obtained from Sweetwater County permit issuing authorities if the move is halted due to weather or emergency circumstances. This change will require an authority number on the altered permit.
- (iii) Permit(s) for completed Class C and Class R super load moves must be faxed, mailed, emailed, or delivered to the Sweetwater County Sheriff's Office within 7 days of completing a move. The address and fax number are:

Sweetwater County Sheriff's Office

Mail to: 50140B US 191 South

Rock Springs, WY 82901

Physically drop off at: 50140B US 191 South

Rock Springs, WY 82901

Phone: 307-922-5300, Fax: 307-922-5483

Email: ~~XXXXXXXXXX~~ roadpermits@sweetwatercountywy.gov

- (iv) If a permit is lost or destroyed, the holder shall notify Sweetwater County Sheriff's Office at once.
- (v) An unreported and missing permit may result in a \$100.00 fee. This fee is per missing permit and will be due before any additional class C permits are issued.

(e) Submission of Fees

- (i) County ~~class B Annual and~~ class C permits will be paid for when they are issued to the carrier.
- (ii) The fee for undocumented, lost, or missing permits are non-refundable, and those permit numbers will be considered null and void. The fees must be paid before any additional county class C permits are issued.

- (iii) In addition to corrective actions allowed by law, county class C permits acquired by a check resulting in non-payment will immediately become null and void. Permits may be reinstated when the funds are received.

(f) Company Name Change or Return of Unissued Permits

- (i) Permit holders who are leased, acquired, or otherwise have a name change may submit an application for the transfer of previously issued permits.

- (ii) Permit fees paid will not be refunded for the return of unused permits.

- (g) **County Class R (rig move) pre-purchase permits** are issued for an extended period, valid on Sweetwater County County Roads, and allowing for the movement of a drilling rig and supporting components but does not include the movement of oversize and/or overweight equipment facilitating the move, but which is not a part of the rig.

- (h) **Application and Accountability** – County Class R permits will be issued to companies requesting them only after:

- (i) Completing the prescribed application for pre-purchased county permits.
- (ii) Providing proof of authority to operate in Wyoming as a commercial carrier.

~~(iii) Attending a pre-purchased permitting class administered by the Sweetwater County Sheriff's Office.~~

~~(iv)~~ (iii) Paying the established fee for the permit issued.

~~(v)~~ (iv) Having accounted for any permits currently held.

(i) Penalty for Misuse or Abuse of Pre-purchased Permits

- (i) Holders of self-issuing permits shall be responsible for the proper use and preparation of self-issuing permits as well as proper training of all personnel involved in the use and preparation of pre-purchased permits. An audit or investigation by Sweetwater County permit issuing authorities revealing any discrepancies in the permit holder's operation (such as improperly completed permits, habitual or recurrent violations, frequently missing permits or non-payment of fees, and so forth) may result in the permit holder's self-issuing permit privileges being suspended, canceled, or revoked. Participation in the Self-Issuing Permit Program is a privilege, not a guaranteed right.

Section 16: Procedure for Obtaining Classes of Permits

- (a) Request for all classes of permits shall be made to permit issuing authorities as listed in Section 4. An approved application may be submitted via online portal, fax, ~~or email~~, or in person. This information can be found on the Sweetwater County website: www.sweetwatercountywy.gov. Applications for permits submitted via fax, email, or delivered in person may be approved by the Sweetwater County Sheriff's Office Monday through Friday from 8:00 a.m. to 4:00 p.m., holidays excluded. Applications for permits submitted through the online portal may be approved outside of these hours at any time, subject to staff availability by Sweetwater County Sheriff's Office.
- (b) The following information may be needed from individuals and companies requesting any class of permit before approval is given:
- (i) The name of the company or individual responsible for the move;
 - (ii) The address and telephone number of the applicant;
 - (iii) The name of the individual requesting permission;
 - (iv) A definitive description of the load to be moved (make, model, unit number, serial number, etc.);
 - (v) The origin and destination for the move;
 - (vi) The proposed route of movement, including all roads to be used;
 - (vii) The axle configuration including distances between axles and tire size;
 - (viii) The axle and gross weights;
 - (ix) The overall length, single vehicle length(s), rear overhang length, width, and height of proposed load;
 - (x) All appropriate license numbers, US DOT number, regulatory authority information, and unit numbers;
 - (xi) Any other requested information concerning the move.

- (c) The permit issuing authorities as listed in Section 4, "Permit-issuing Authorities and Types of Permits Available," may impose restrictions, requirements for lighter loads, alternate

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routes, or other conditions to ensure the structural integrity of the county road system while minimizing the inconvenience to other roadway users.

- (d) Requests for all classes of permits may be approved if the movement does not exceed the limits indicated in the applicable tables. For some moves, a thorough study of the proposed route is necessary and may require 48 or more hours to complete.
- (e) Requests for all classes of permits shall be processed upon approval and receipt of the proper permit fees. Paper copies, or digital copies sent prior to the move, shall be accepted for all classes of permits.

Section 17: Class D Permits

- (a) Permits may be obtained for a period not exceeding one year. These permits shall authorize the movement of vehicles without load or meeting non-divisible load requirements. Class D permits shall also authorize movement of a trailer carrying a recreational boat that exceeds statutory weight limits and/or size limits up to 12 feet wide, 15 feet high, and 75 feet long for single vehicles. Class D permits are not authorized for transportable homes.
- (b) Class D oversize permits are issued to a specific unit, and if applicable, power unit, and/or load (a vehicle identification number or serial number shall be required for each specific piece of equipment indicated on the permit). If a piece of equipment is not shown on the permit, the permit is not valid for the move. Oversize vehicles may transport legal sized loads providing this is indicated on the permit.
- (c) If required, vehicle(s) shall be properly qualified with Wyoming registration. Trip permits in lieu of vehicle registration shall not be allowed.
- (d) Multiple legal sized power units owned or leased and operated by the carrier may be indicated on the permit for size only.
- (e) Oversize power units may pull a trailer providing that specific trailer is indicated on the permit.
- (f) Class D oversize permits shall be obtained from the permit issuing authorities as listed in Section 4, "Permit-issuing Authorities and Types of Permits Available." Applicants shall submit the information as directed in Section 16, "Procedure for Obtaining Classes of Permits."
- (g) Class D overweight permits shall be obtained from Sweetwater County permit issuing authorities.
- (h) Class D overweight permits are issued to a specific power unit, and if applicable specific trailer and/or load (a vehicle identification number or serial number shall be required for

TERRY R. PITT CONSTRUCTION

180 Pollux Drive,
Rock Springs, WY 82901
Phone: 307 362-8077



Date: June 18, 2026

Sweetwater County Board of County Commissioners
80 West Flaming Gorge Way, Suite 150
Green River, WY 82935

Via Email: shoemakers@sweetwatercountywy.gov

Re: Opposition to Proposed Amendments to Sweetwater County Rules and Regulations Governing Vehicle Size, Weight, and Permitting (Resolution 2026-03-CC-02)

Dear Commissioners:

I am writing on behalf of Terry R. Pitt Construction, Inc., a family-owned excavation and groundworks company with approximately 35 employees operating in Sweetwater County. As Director of Regulatory Affairs and Safety, I respectfully submit these comments in strong opposition to the proposed amendments that would impose new county permit requirements for oversized and overweight vehicles and loads on County Roads.

While we support the goal of safe and orderly use of county roads, these proposed changes will create significant and unnecessary burdens on local businesses like ours that routinely operate trucks, trailers, and heavy equipment (dozers, excavators, scrapers, haul trucks, etc.) on county roads as part of essential oil and gas infrastructure work.

Our primary concerns include:

1. **Duplicative and Unnecessary Costs:** As a local business and significant taxpayer in Sweetwater County, we already contribute substantially through property taxes, business taxes, and other revenues that fund county road maintenance and operations. Imposing additional permit fees on top of existing state permits from the Wyoming Highway Patrol represents an unnecessary extra financial burden on those already supporting the road system.
2. **Operational Delays and Lack of Nimbleness:** Our work in the oil and gas industry requires rapid response and flexibility. The proposed process requires a 3-day waiting period and relies on human processing rather than an online self-service system. These delays will hinder our ability to respond quickly to project needs and could make it impossible to remain competitive.
3. **Process Concerns:** These requirements appear to have been initially imposed without public comment. This subsequent comment period, while appreciated, comes after the rules have already created disruption for operators.
4. **Significant Economic Impact on Local Industry:** Internal accounting and bookkeeping analyses project a substantial annual increase in compliance costs that will directly impact our bottom line. These figures can be provided upon request. These added costs will have to be recovered somewhere—most likely to be charged back to the oil and gas companies we serve—which will in turn affect their project economics. In the long term, these cumulative burdens could put our company out of business, resulting in the loss of jobs for our 35 employees and reduced economic activity in Sweetwater County.
5. **Unnecessary Tarp Requirements:** The proposed rules appear to impose tarp or load-securing requirements based on federal standards. These do not apply in the same manner to typical rocks, gravel, and aggregate loads commonly hauled in our industry (per FMCSA exemptions for bulk commodities in 49 CFR 393), yet they would add further compliance costs and complexity with no corresponding safety benefit for such materials.

We urge the Board to reconsider or significantly modify these proposed amendments. At minimum, we recommend:

- Eliminating or substantially reducing county permit requirements for loads that already comply with valid state permits;
- Implementing a true online self-issue system similar to Class C permits;
- Exempting routine local construction and resource industry equipment moves; and
- Removing or clarifying the tarp requirements for aggregate materials.

Thank you for the opportunity to comment. We are available to meet with the Board, the Sheriff's Office, or Public Works staff to discuss practical solutions that maintain safety while supporting the economic engine of Sweetwater County. Please feel free to contact me directly.

Sincerely,

Bob Keys

Director of Regulatory Affairs

Terry R. Pitt Construction, Inc.

Phone: 307-350-2251 Email: bob.keys@pitt-construction.com



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: vanmatrec@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: Kassidee Brown, Planner	Exact Wording for Agenda: 26-07-ZO-01 A Zoning Map Amendment for approximately 320 acres more or less to be amended from Agriculture (A) and Mineral Development (MD-1) to add a Mineral Development (MD-2) Overlay
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 10 Minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: 26-07-Z0-01.pdf ZMA-A & MD-1 add MD-2 Overlay_ Resolution.docx	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov
*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov

- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item may be rescheduled.
- In order to determine placement on the agenda, please review the county website sweetwatercountywy.gov on Thursday afternoon by clicking “Commissioner's Agenda”.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[26-07-Z0-01.pdf](#)

[ZMA-A & MD-1 add MD-2 Overlay_ Resolution.docx](#)

Property Owner: US Bureau of Reclamation

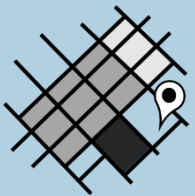
Applicant: Tyler Schiltz- Sisecam Wyoming LLC

Legal Description: Approximately 320 acres of land in the NW, NE Sec. 2, T19N, R109W

Address: NA

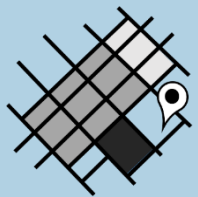
Current Zoning: Agriculture (A) and Mineral Development (MD-1)

Infrastructure: Access off State HWY 372

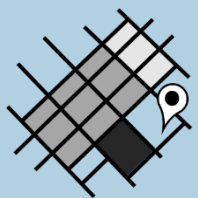
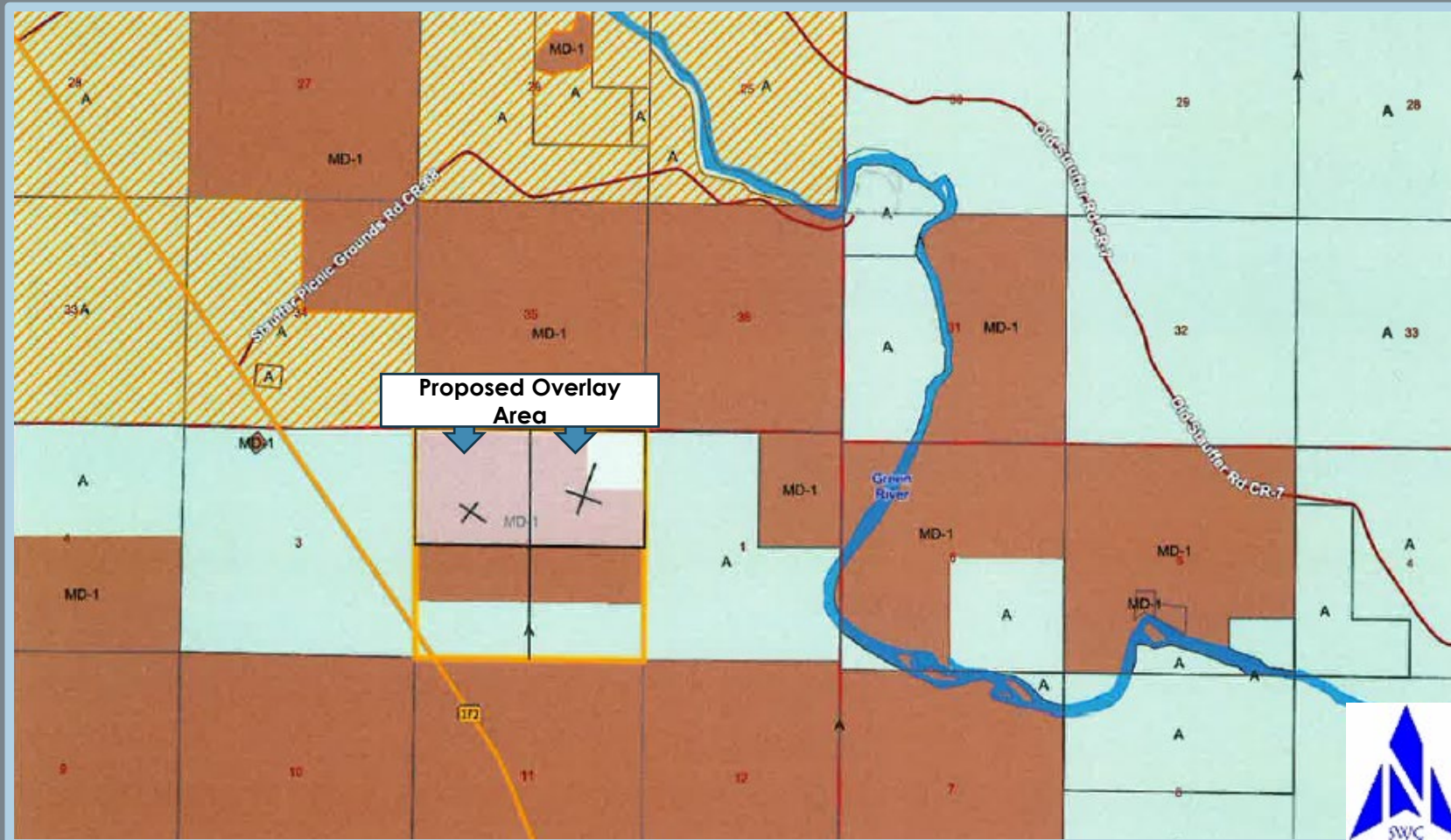


TYLER SCHILTZ- SISECAM WYOMING LLC
ZMA- A & MD-1 ADD MD-2 OVERLAY

Tyler Schiltz on behalf of Sisecam Wyoming LLC, is proposing to add a Mineral Development (MD-2) overlay to approximately 320 acres of land that is currently zoned for Agriculture and Mineral Development (MD-1) use. Surface ownership is the US Bureau of Reclamation and mineral ownership is Bureau of Land Management. This is an overlay district intended to accommodate underground mining in conjunction with the surface uses of the base zoning district(s). There are no surface features or disturbances proposed by the applicant in this section.



APPLICATION SUMMARY



ZONING MAP



View to the North



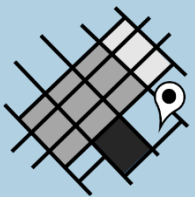
Public Notice
6/08/2026

View to the East



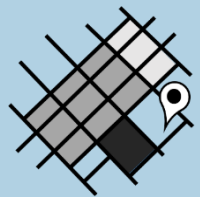
View to the South

View to the West



SITE PHOTOS

1. The amendment is consistent and compatible with current resolution and the Comprehensive Plan.
2. The proposed zoning is suitable for the existing topography and creates buildable lots.
3. The proposed zoning is compatible with existing or allowable uses of adjacent properties and neighboring zoning districts.
4. The proposed zoning can demonstrate adequate public facilities including roads, drainage, potable water, sanitary sewer, and police and fire protection exist or will exist to serve the requested use at the time such facilities are needed.
5. The amendment shall not adversely affect adjacent properties, communities or the health safety and welfare of the residents of Sweetwater County.
6. The request conforms to all applicable provisions of this Resolution.



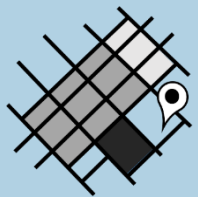
REVIEW CRITERIA FOR ZMA

1. The amendment is consistent and compatible with the current resolution and the Comprehensive Plan.

This amendment encourages growth and development to continue in an orderly manner and in locations that contribute to the economic and social well-being of County residents.

2. The proposed zoning is suitable for the existing topography and creates buildable lots.

This proposed zoning is suitable for the existing topography and does help to create a more buildable parcel.



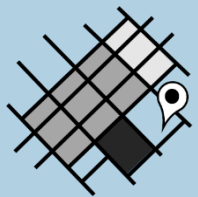
REVIEW CRITERIA FOR ZMA

3. The proposed zoning is compatible with existing or allowable uses of adjacent properties and neighboring zoning districts.

This parcel is located in an area that is overwhelmingly zoned for Mineral Development. The adjacent parcel to the North-West of the proposed zoning area also has a MD-2 overlay.

4. The proposed zoning can demonstrate adequate public facilities including roads, drainage, potable water, sanitary sewer, and police and fire protection exist or will exist to serve the requested use at the time such facilities are needed.

There are adequate public facilities already located on the existing property to accommodate the requested overlay district.



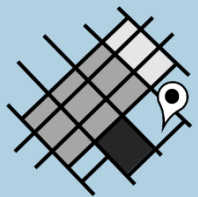
REVIEW CRITERIA FOR ZMA

5. The amendment shall not adversely affect adjacent properties, communities or the health safety and welfare of the residents of Sweetwater County.

Staff does not foresee that this amendment will adversely affect adjacent properties. We have not received any negative comments.

6. The request conforms to all applicable provisions of this Resolution.

This amendment conforms with the 2015 SWC Zoning Resolution.

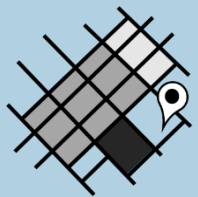


REVIEW CRITERIA FOR ZMA

Darin Kaufman-WYDOT: "WYDOT has no objections for the proposed underground mining zone changes."

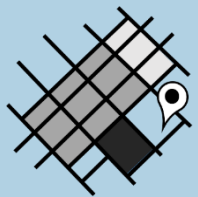
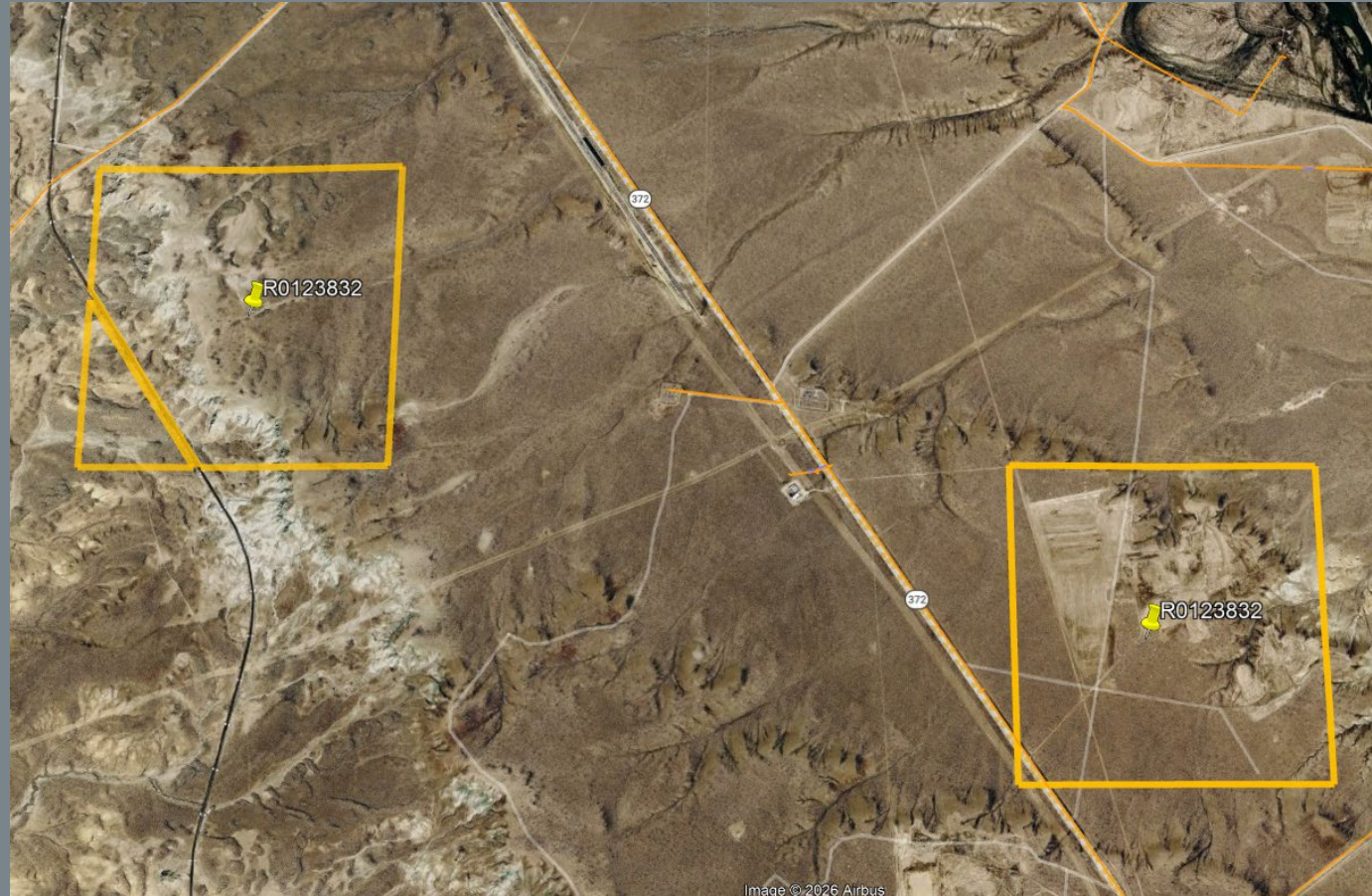
Melissa Laber- "These properties have no AML concerns with regard to abandoned historic mines."

Erin Boling- Rocky Mountain Power: "I have discussed this with Tyler (applicant) and I do not have any comments or concerns."



PUBLIC/AGENCY COMMENTS

Mark Beery-Lumen: "We show copper on 372 and nearby at R0123832 (Account #)." (Image provided by Mr. Beery)

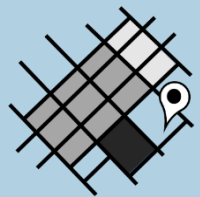


PUBLIC/AGENCY COMMENTS

Land Use Staff Comments:

Staff recommends approval of ZMA Recommendation 26-07-ZO-01 to add an MD-2 Overlay to approximately 320 acres of land currently zoned A and MD-1 as requested by Tyler Schiltz on behalf of Sisecam Wyoming LLC.

At the July 15, 2026 Planning and Zoning Commission Meeting the P&Z Commission voted 3-0 to recommend approval of Resolution 26-07-ZO-01 for a ZMA adding an MD-2 Overlay to approximately 320 acres of land currently zoned A and MD-1 as requested by the applicant.



STAFF RECOMMENDATIONS

**Recommendation 26-07-ZO-01 for Approval of
A Zoning Map Amendment
From A & MD-1 to A and MD-1 with a MD-2 Overlay Requested by Tyler
Schiltz on behalf of Sisecam Wyoming LLC**

WHEREAS, Tyler Schiltz on behalf of Sisecam Wyoming LLC is requesting a Zoning Map Amendment from Agriculture (A) and Mineral Development (MD-1) to Agriculture (A) and Mineral Development (MD-1) with a Mineral Development (MD-2) overlay in accordance with Amendment Procedures found in Section 20 of the 2015 Zoning Resolution; and,

WHEREAS, this Zoning Map Amendment will be approved for approximately 320 acres of land owned by the U.S. Bureau of Reclamation which is legally described as:

The NW4 and NE4 of Section 2, Township 19 North, Range 109 West of the 6th Principal Meridian, Sweetwater County, Wyoming.

WHEREAS, the Sweetwater County Planning and Zoning Commission held a public hearing in accordance with the procedural requirements of the 2015 Zoning Resolution on July 15, 2026 to consider the applicant's request; and,

WHEREAS, after due consideration and discussion, the Planning and Zoning Commission voted 3-0 to recommend approval of the Zoning Map Amendment from Agriculture (A) and Mineral Development (MD-1) to Agriculture (A) and Mineral Development (MD-1) with a Mineral Development (MD-2) overlay.

NOW THEREFORE, the Sweetwater County Planning and Zoning Commission recommends APPROVAL of the Zoning Map Amendment Agriculture (A) and Mineral Development (MD-1) to Agriculture (A) and Mineral Development (MD-1) with a Mineral Development (MD-2) overlay in accordance with Amendment Application #2026-005 and the 2015 Zoning Resolution.

Dated this 15th day of July 2026

Attest:

Sweetwater County
Planning and Zoning Commission

Cynthia L. Swenson, County Clerk

Mark Lyon, Chairman

**RESOLUTION 26-07-ZO-01 FOR APPROVAL OF
A ZONING MAP AMENDMENT
FROM A & MD-1 TO A AND MD-1 WITH A MD-2 OVERLAY REQUESTED BY TYLER
SCHILTZ ON BEHALF OF SISECAM WYOMING LLC**

WHEREAS, Tyler Schiltz on behalf of Sisecam Wyoming LLC is requesting a Zoning Map Amendment from Agriculture (A) and Mineral Development (MD-1) to Agriculture (A) and Mineral Development (MD-1) with a Mineral Development (MD-2) overlay in accordance with Amendment Procedures found in Section 20 of the 2015 Zoning Resolution; and,

WHEREAS, this Zoning Map Amendment will be approved for approximately 320 acres of land owned by the U.S. Bureau of Reclamation which is legally described as:

The NW4 and NE4 of Section 2, Township 19 North, Range 109 West of the 6th Principal Meridian, Sweetwater County, Wyoming.

WHEREAS, the Sweetwater County Board of County Commissioners held a public hearing in regards to this matter on July 21, 2026 and has given due consideration to the recommendation of the Planning and Zoning Commission and to all the evidence and testimony presented at the hearing;

NOW THEREFORE BE IT RESOLVED that the Sweetwater County Board of County Commissioners **APPROVES** of the Zoning Map Amendment from Agriculture (A) and Mineral Development (MD-1) to Agriculture (A) and Mineral Development (MD-1) with a Mineral Development (MD-2) overlay in accordance with the 2015 Zoning Resolution and Amendment Application #2026-005.

Dated this 21st day of July 2026.

Sweetwater County
Board of County Commissioners

Keaton D. West, Chairman

Taylor C. Jones, Member

Island Richards, Member

Robert D. Slaughter, Member

ATTEST:

Cynthia L. Swenson, County Clerk

Mary E. Thoman, Member



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: vanmatrec@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: Kassidee Brown, Planner	Exact Wording for Agenda: 26-07-ZO -02 A Zoning Map Amendment for approximately 160 acres more or less to be amended from Agriculture (A) to add a Mineral Development (MD-2) Overlay
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 10 Minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: ZMA-A add MD-2 Overlay_ Resolution.docx July 21, 2026 BCC Staff Report PH.2.pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov
If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.
- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send

a representative in your place or your item may be rescheduled.

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The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[ZMA-A add MD-2 Overlay_ Resolution.docx](#)

[July 21, 2026 BCC Staff Report PH.2.pdf](#)

**RESOLUTION 26-07-ZO-02 FOR APPROVAL OF
A ZONING MAP AMENDMENT
FROM AGRICULTURE (A) TO AGRICULTURE (A) WITH A MINERAL
DEVELOPMENT (MD-2) OVERLAY REQUESTED BY TYLER SCHILTZ ON BEHALF
OF SISECAM WYOMING LLC**

WHEREAS, Tyler Schiltz on behalf of Sisecam Wyoming LLC is requesting a Zoning Map Amendment from Agriculture (A) to Agriculture (A) with a Mineral Development (MD-2) Overlay in accordance with Amendment Procedures found in Section 20 of the 2015 Zoning Resolution; and,

WHEREAS, this Zoning Map Amendment will be approved for approximately 160 acres of land owned by the U.S. Bureau of Reclamation which is legally described as:

W2NE4 and W2SE4 of Section 32, Township 20 North, Range 109 West of the 6th Principal Meridian, Sweetwater County, WY

WHEREAS, the Sweetwater County Board of County Commissioners held a public hearing in regards to this matter on July 21, 2026 and has given due consideration to the recommendation of the Planning and Zoning Commission and to all the evidence and testimony presented at the hearing;

NOW THEREFORE BE IT RESOLVED that the Sweetwater County Board of County Commissioners **APPROVES** of the Zoning Map Amendment from Agriculture (A) to Agriculture (A) with a Mineral Development (MD-2) Overlay in accordance with the 2015 Zoning Resolution and Amendment Application #2026-004.

Dated this 21st day of July 2026.

Sweetwater County
Board of County Commissioners

Keaton D. West, Chairman

Taylor C. Jones, Member

Island Richards, Member

ATTEST:

Robert D. Slaughter, Member

Cynthia L. Swenson, County Clerk

Mary E. Thoman, Member

Property Owner: BLM

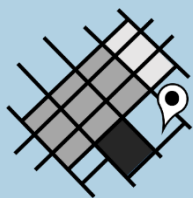
Applicant: Tyler Schiltz- Sisecam Wyoming LLC

Legal Description: Approximately 160 acres of land in W2NE4, W2SE4 Sec. 32 T20N R109W

Address: N/A

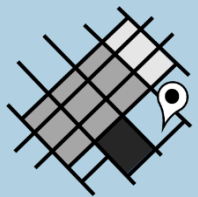
Current Zoning: Agriculture (A)

Infrastructure:

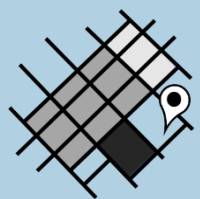
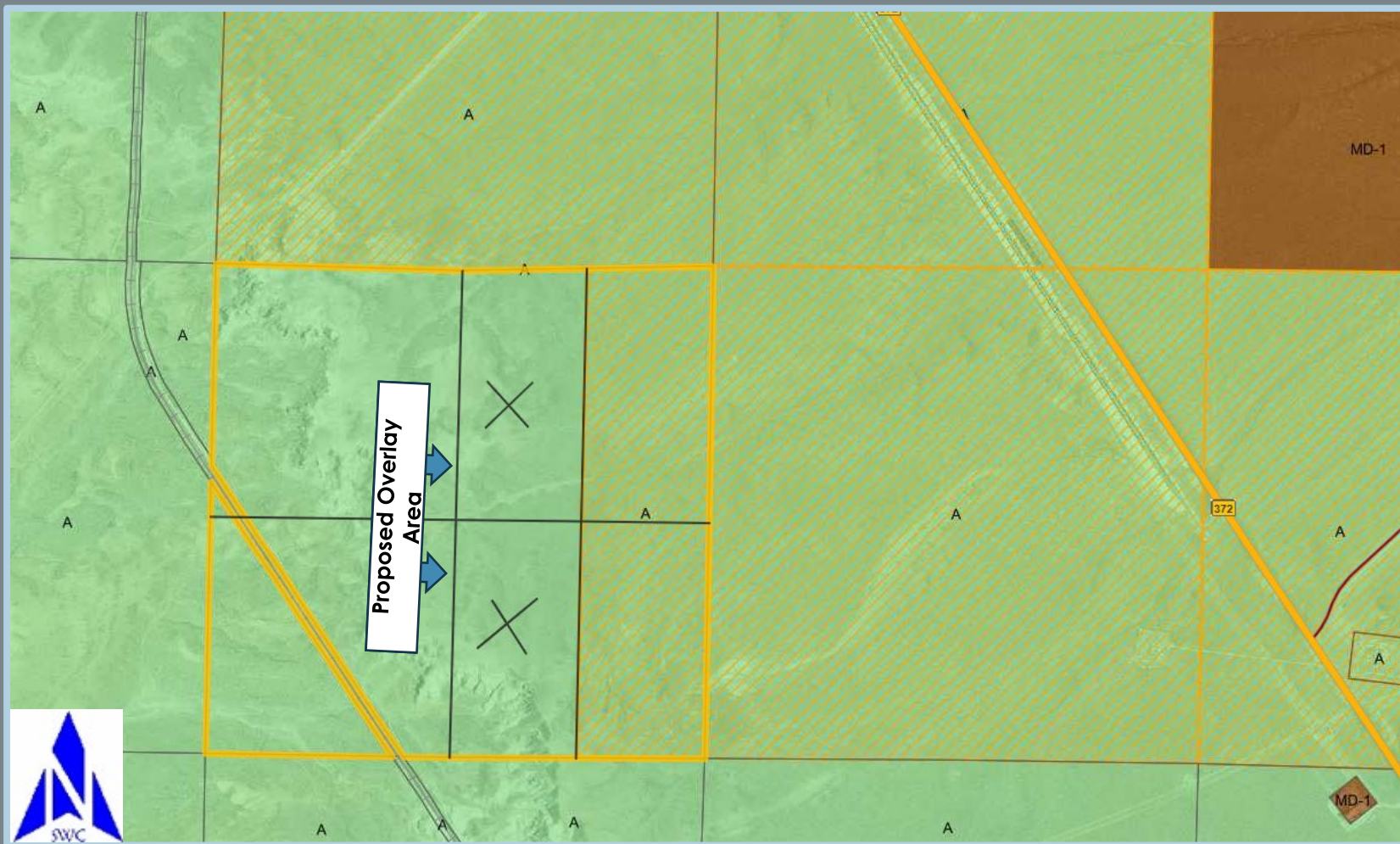


TYLER SCHILTZ- SISECAM WYOMING LLC
ZMA-MD-1 ADD MD-2 OVERLAY

Tyler Schiltz on behalf of Sisecam Wyoming LLC, is proposing to add a Mineral Development (MD-2) overlay to approximately 160 acres of land that is currently zoned for Agriculture use. Surface ownership is the US Bureau of Reclamation and mineral ownership is Bureau of Land Management. This is an overlay district intended to accommodate underground mining in conjunction with the surface uses of the base zoning district(s). There are no surface features or disturbances proposed by the applicant in this section.



APPLICATION SUMMARY



ZONING MAP



View to the North



Public Notice
6/08/2026



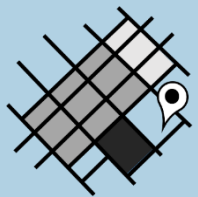
View to the East



View to the South

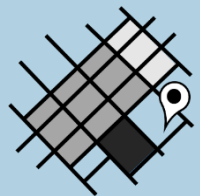


View to the West



SITE PHOTOS

1. The amendment is consistent and compatible with current resolution and the Comprehensive Plan.
2. The proposed zoning is suitable for the existing topography and creates buildable lots.
3. The proposed zoning is compatible with existing or allowable uses of adjacent properties and neighboring zoning districts.
4. The proposed zoning can demonstrate adequate public facilities including roads, drainage, potable water, sanitary sewer, and police and fire protection exist or will exist to serve the requested use at the time such facilities are needed.
5. The amendment shall not adversely affect adjacent properties, communities or the health safety and welfare of the residents of Sweetwater County.
6. The request conforms to all applicable provisions of this Resolution.



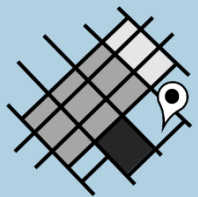
REVIEW CRITERIA FOR ZMA

1. The amendment is consistent and compatible with the current resolution and the Comprehensive Plan.

This amendment encourages growth and development to continue in an orderly manner and in locations that contribute to the economic and social well-being of County residents.

2. The proposed zoning is suitable for the existing topography and creates buildable lots.

This proposed zoning is suitable for the existing topography and does help to create a more buildable parcel.



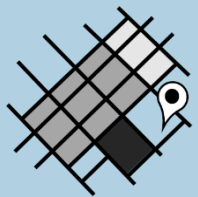
REVIEW CRITERIA FOR ZMA

3. The proposed zoning is compatible with existing or allowable uses of adjacent properties and neighboring zoning districts.

Multiple adjacent properties are already zoned A (Agriculture) with an MD-2 overlay.

4. The proposed zoning can demonstrate adequate public facilities including roads, drainage, potable water, sanitary sewer, and police and fire protection exist or will exist to serve the requested use at the time such facilities are needed.

There are adequate public facilities already located on the existing property.



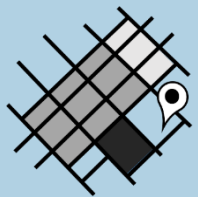
REVIEW CRITERIA FOR ZMA

5. The amendment shall not adversely affect adjacent properties, communities or the health safety and welfare of the residents of Sweetwater County.

This amendment does not adversely affect adjacent properties. We have not received any negative comments.

6. The request conforms to all applicable provisions of this Resolution.

This amendment conforms with the 2015 SWC Zoning Resolution.

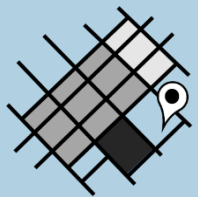


REVIEW CRITERIA FOR ZMA

Darin Kaufman-WYDOT: "WYDOT has no objections for the proposed underground mining zone changes. Additional information on State Highway 372 access, utilities, and subsidence must eventually be provided by the applicant."

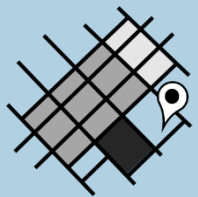
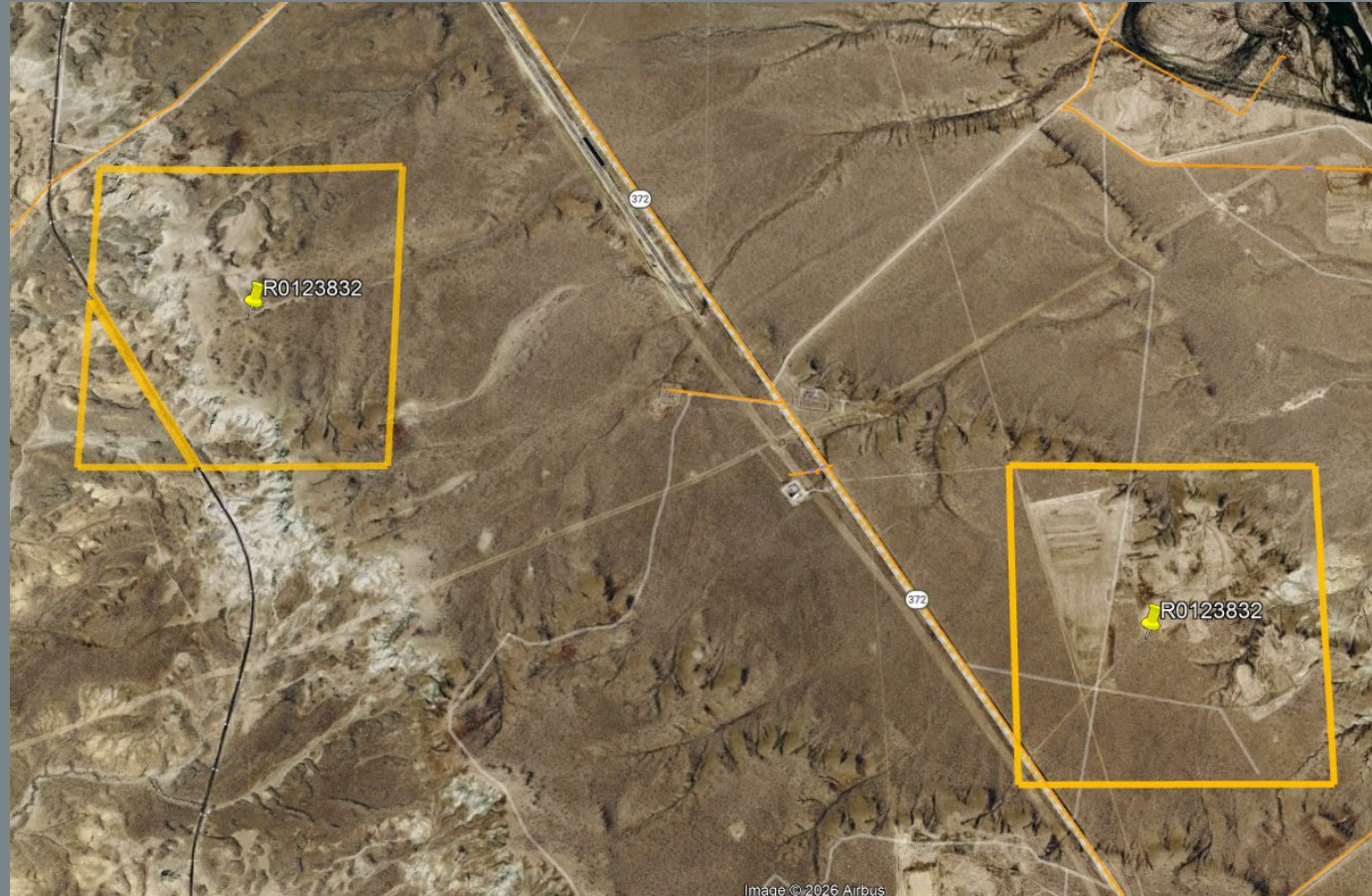
Melissa Laber- "These properties have no AML concerns with regard to abandoned historic mines."

Erin Boling- Rocky Mountain Power: "I have discussed this with Tyler (applicant) and I do not have any comments or concerns."



PUBLIC/AGENCY COMMENTS

Mark Beery-Lumen: "We show copper on 372 and nearby at R0123832 (Account #)." (Image provided by Mr. Beery)

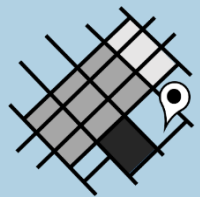


PUBLIC/AGENCY COMMENTS

Land Use Staff Comments:

Staff recommends approval of ZMA Recommendation 26-07-ZO-02 to add an MD-2 Overlay to approximately 160 acres of land currently zoned A as requested by Tyler Schiltz on behalf of Sisecam Wyoming LLC.

At the July 15, 2026 Planning and Zoning Commission Meeting the P&Z Commission voted 3-0 to recommend approval of Resolution 26-07-ZO-02 for a ZMA adding an MD-2 Overlay to approximately 160 acres of land currently zoned A as requested by the applicant.



STAFF RECOMMENDATIONS

**Recommendation 26-07-ZO-02 for Approval of
A Zoning Map Amendment
From Agriculture (A) to Agriculture (A) with a Mineral Development (MD-2)
Overlay Requested by Tyler Schiltz on behalf of Sisecam Wyoming LLC**

WHEREAS, Tyler Schiltz on behalf of Sisecam Wyoming LLC is requesting a Zoning Map Amendment from Agriculture (A) to Agriculture (A) with a Mineral Development (MD-2) Overlay in accordance with Amendment Procedures found in Section 20 of the 2015 Zoning Resolution; and,

WHEREAS, this Zoning Map Amendment will be approved for approximately 160 acres of land owned by the U.S. Bureau of Reclamation which is legally described as:

W2NE4 and W2SE4 of Section 32, Township 20 North, Range 109 West of the 6th Principal Meridian, Sweetwater County, WY.

WHEREAS, the Sweetwater County Planning and Zoning Commission held a public hearing in accordance with the procedural requirements of the 2015 Zoning Resolution on July 15, 2026 to consider the applicant's request; and,

WHEREAS, after due consideration and discussion, the Planning and Zoning Commission voted 3-0 to recommend approval of the Zoning Map Amendment from Agriculture (A) to Agriculture (A) with a Mineral Development (MD-2) Overlay.

NOW THEREFORE, the Sweetwater County Planning and Zoning Commission recommends APPROVAL of the Zoning Map Amendment from Agriculture (A) to Agriculture (A) with a Mineral Development (MD-2) Overlay in accordance with Amendment Application #2026-004 and the 2015 Zoning Resolution.

Dated this 15th day of July 2026

Attest:

Sweetwater County
Planning and Zoning Commission

Cynthia L. Swenson, County Clerk

Mark Lyon, Chairman



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3897
Presenters Name, Title and Name of Organization: BOCC	Exact Wording for Agenda: Approval of the June 30, 2026 Minutes
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: 2026-06-30 BUDGET ADOPTION MEETING MINUTES WITH ATTACHMENTS.pdf	

INSTRUCTIONS:

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*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item may be rescheduled.
- In order to determine placement on the agenda, please review the county website sweetwatercountywy.gov on Thursday afternoon by clicking “Commissioner's Agenda”.

- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[2026-06-30 BUDGET ADOPTION MEETING MINUTES WITH ATTACHMENTS.pdf](#)

June 30, 2026
Green River, WY

PRELIMINARY:

PLEDGE OF ALLEGIANCE

Chairman West opened the meeting with the Pledge of Allegiance.

ROLL CALL / QUORUM PRESENT

The Board of County Commissioners met this day at 8:30 a.m., with Chairman West and Commissioners Richards, Slaughter, and Thoman present.

A) PUBLIC HEARING

A.1) Resolution to Provide the Revenues Necessary to Finance the Budget for the Fiscal Year Beginning July 1, 2026, and ending June 30, 2027

Department: County Clerk

[Cover Page](#) 

[Resolution Draft - 6.19.2026.pdf](#) 

Accounting Specialist Rebecca Romero presented the Resolution to Provide Revenues Necessary to Finance the Budget for Fiscal Year 2027. Ms. Romero explained that various fiscal scenarios had been incorporated into the final check run and noted that the receipt of Payment in Lieu of Taxes (PILT) funding had placed the County in a significantly stronger financial position.

Discussion ensued among the Board regarding potential adjustments before final adoption, specifically focusing on:

- Revisiting the Cost of Living Allowance (COLA) for county employees.
- Re-evaluating pending capital projects across the county.
- Reviewing the operational budget for the Young at Heart Senior Citizens Center throughout the year with the option of increasing their budget.

Chairman West opened the public hearing. Hearing no comments, the public hearing was closed.

Chairman West entertained a motion to adopt the Fiscal Year 2027 Resolution to Provide Revenues Necessary to Finance the Budget. ***Island Richards moved to approve. Robb Slaughter seconded the motion.*** The motion carried.

The Commission expressed appreciation to Accounting Specialist Rebecca Romero for her hard work during the budget process.

RESOLUTION TO PROVIDE REVENUES NECESSARY TO FINANCE THE BUDGET

WHEREAS, on the 30th day of June, 2026, the Board of County Commissioners adopted the official County Budget for the fiscal year beginning July 1, 2026, and ending June 30, 2027; and

WHEREAS, said budget includes appropriations as summarized below:

County Departments

Category	FY 2027 Budgeted
PAYROLL	
COUNTY COMMISSIONERS	\$395,161
ENGINEERING	\$478,168
FACILITIES CUSTODIAL	\$1,076,709
FACILITIES MAINTENANCE	\$622,512
FLEET/VEHICLE MAINTENANCE	\$255,701
GRANTS ADMIN	\$176,106
HUMAN RESOURCES	\$481,065
IT	\$1,106,450
LAND USE	\$523,441
PURCHASING	\$470,353
VETERANS SERVICES	\$300,556
SPT 23 JOINT POWERS BOARD	\$7,862
COUNTY ASSESSOR	\$909,277
COUNTY ATTORNEY	\$3,307,466
COUNTY CLERK	\$1,367,762
CLRK-COMMISSIONER SUP	\$125,877
CLRK-ELECTIONS	\$341,349
CLERK OF DISTRICT COURT	\$794,454
COUNTY TREASURER	\$1,045,977
JUVENILE PROBATION	\$538,787
COUNTY CORONER	\$365,666
COUNTY SHERIFF	\$6,243,051
SHRF-DETENTION CNTR	\$5,169,009
ANIMAL CONTROL	\$88,754
ROAD AND BRIDGE	\$2,711,790
FACILITIES PARKS AND REC	\$476,242
Total PAYROLL	\$29,379,545
OPERATING	
COUNTY COMMISSIONERS	\$154,150
ENGINEERING	\$53,160
FACILITIES CUSTODIAL	\$60,100
FACILITIES MAINTENANCE	\$425,250
FAC MAINT-GR CIRCUIT CT	\$4,060
FAC MAINT-GR ROOSEVELT	\$53,400
FAC MAINT-GR WAREHOUSE	\$4,850
FAC MAINT-RS 731 B	\$8,450

FAC MAINT-RS 731 C	\$450
FAC MAINT-RS ATTORNEY/CIRCUIT	\$99,500
FAC MAINT-RS LAYOS GEN	\$55,000

Category	FY 2027 Budgeted
FAC MAINT-RS MAINT/PURCH	\$16,500
FAC MAINT-RS VEHICLE MAINT	\$13,200
FLEET/VEHICLE MAINTENANCE	\$151,625
GENERAL COUNTY ADMIN GEN	\$285,124
GRANTS ADMIN	\$3,285
HUMAN RESOURCES	\$33,050
HR-RISK MANAGEMENT	\$1,017,070
HR-EMPLOYEE BENEFITS	\$26,500
IT	\$1,150,420
LAND USE	\$53,350
LAND USE-ECONOMIC DEVELOPMENT	\$85,050
PURCHASING	\$24,800
VETERANS SERVICES	\$37,950
SPT 23 JOINT POWERS BOARD	\$43,500
COUNTY ASSESSOR	\$275,720
COUNTY ATTORNEY	\$162,175
COUNTY CLERK	\$155,700
CLRK-ELECTIONS	\$198,000
CLERK OF DISTRICT COURT	\$83,800
COUNTY TREASURER	\$98,520
FAC MAINT-RS 731 A PS	\$43,200
FAC MAINT-RS 731 D	\$3,300
FAC MAINT-RS DETENTION CENTER	\$286,500
FAC MAINT-RS IMPOUND/STORAGE	\$5,000
FAC MAINT-RS SHERIFFS BLDG	\$22,750
FAC MAINT-WAM SHRF HOUSE	\$2,000
FIRE MARSHALL	\$423,450
JUVENILE PROBATION	\$17,700
COUNTY CORONER	\$91,075
COUNTY SHERIFF	\$855,618
SHRF-DETENTION CNTR	\$957,750
SHRF-EMER MGMT/HL SEC	\$29,390
ANIMAL CONTROL	\$24,200
FAC MAINT-GR R&B	\$10,000
FAC MAINT-RS LAYOS R&B	\$23,000
FAC MAINT-RS R&B	\$540
FAC MAINT-RS R&B LAGOON	\$1,000
FAC MAINT-FARSON R&B	\$8,500
ROAD AND BRIDGE	\$1,152,750
FAC MAINT-RS BROADWAY	\$85,000
FAC MAINT-RS LAYOS HRW	\$5,500
FACILITIES PARKS AND REC	\$250,775
GENERAL COUNTY ADMIN CONSV	\$300
Total OPERATING	\$9,133,007
CAPITAL	
ENGINEERING	\$2,500
FACILITIES CUSTODIAL	\$5,350

FACILITIES MAINTENANCE	\$5,000
FLEET/VEHICLE MAINTENANCE	\$5,000
HUMAN RESOURCES	\$3,500

Category	FY 2027 Budgeted
HR-RISK MANAGEMENT	\$45,000
IT	\$10,000
LAND USE	\$2,000
PURCHASING	\$3,500
VETERANS SERVICES	\$500
COUNTY CLERK	\$1,400
COUNTY TREASURER	\$6,000
FAC MAINT-RS DETENTION CENTER	\$11,184
COUNTY CORONER	\$5,500
ROAD AND BRIDGE	\$5,000
FACILITIES PARKS AND REC	\$5,000
CAPITAL & EXENDITURES >10K	\$4,048,598
Total CAPITAL	\$4,165,032
Total Expenditures	\$42,677,584

County Grants

Category	FY 2027 Budgeted
GENERAL FUND	\$3,906,088
Total Expenditures	\$3,906,088

Component Units - Summary

Category	FY 2027 Budgeted
GEN EVENTS COMPLEX	\$1,887,628
GEN LIBRARY	\$3,208,358
GEN MUSEUM	\$342,690
GEN SW COUNS	\$391,800
GEN HOSPITAL	\$878,472
GEN BD OF HLTH	\$293,149
Total Expenditures	\$7,002,097

Agency & Other - Summary

Category	FY 2027 Budgeted
BOYS & GIRLS CLUB OF SW CO	\$13,500
CASTLE ROCK HOSPITAL DISTRICT	\$1,700,000
CLIMB WYOMING	\$1,500
FAMILY RESOURCE CENTER	\$20,000
YOUTH HOME	\$62,500
GOLDEN HOUR SENIOR CENTER	\$165,000
YOUNG AT HEART SENIOR CENTER	\$185,000
CONSERVATION DISTRICT	\$160,000
COOPERATIVE EXT/4H	\$119,660
SW CO TRANSIT AUTHORITY	\$89,843
CARBON COUNTY FIRE DISTRICT	\$12,000
GUARDIAN AD LITEM	\$150,000
PUBLIC DEFENDER LEGAL/STATE	\$190,000
RS GR SW CO-COMB COMM JPB	\$993,531
RS SWC AIRPORT	\$374,455
SKYWEST AIRLINES INC	\$896,398
TITLE 25 MEDICAL/LEGAL	\$385,004
Total Expenditures	\$5,518,392

General Fund Revenue by Source

Category	FY 2027 Budgeted
Taxes	\$37,086,750
Licenses & Permits	\$2,021,683
Intergovernmental	\$4,262,208
Charges For Services	\$2,473,563
Investment	\$1,694,270
Misc	\$331,381
Comp For Loss Of Cap Assets	\$57,800
Grants	\$2,559,976
Total Revenues	\$50,487,631

Other Funds

Other Funds - Expenditure Summary

Category	FY 2027 Budgeted
COUNTY ROAD FUND	\$5,490,000
IMPACT TAX FUND	\$650,816
INMATE ENTERPRISE FUND	\$90,000
DRUG SEIZURE	\$164,641
PARKS AND RECREATION	\$70,000
STATE & COUNTY ROADS FUND	\$3,140,000
CDC BUILDING FUND	\$150,000
HEALTH INSURANCE FUND	\$11,314,175
TREATMENT COURT	\$314,771
OPIOID SETTLEMENT	\$500,000
Total Expenditures	\$21,884,403

Other Fund - Revenue Summary

Category	FY 2027 Budgeted
COUNTY ROAD FUND	\$2,304,000
IMPACT TAX FUND	\$511,771
INMATE ENTERPRISE FUND	\$90,000
PARKS AND RECREATION	\$800
STATE & COUNTY ROADS FUND	\$1,095,000
PROBLEMATIC GAMBLING BEHAVIOR	\$30,000
HEALTH INSURANCE FUND	\$11,280,000
TREATMENT COURT	\$318,560
Total Revenues	\$15,630,131

Total Appropriations

Total Appropriations by Fund - Summary

Expenditures by Fund

Category	FY 2027 Budgeted
GENERAL FUND	\$59,104,161
COUNTY ROAD FUND	\$5,490,000
IMPACT TAX FUND	\$650,816
INMATE ENTERPRISE FUND	\$90,000
DRUG SEIZURE	\$164,641
PARKS AND RECREATION	\$70,000
STATE & COUNTY ROADS FUND	\$3,140,000
CDC BUILDING FUND	\$150,000
HEALTH INSURANCE FUND	\$11,314,175
TREATMENT COURT	\$314,771
OPIOID SETTLEMENT	\$500,000
Total Expenditures	\$80,988,564

Revenues by Fund

Revenues by Fund - Summary

Category	FY 2027 Budgeted
GENERAL FUND	\$50,487,631
COUNTY ROAD FUND	\$2,304,000
IMPACT TAX FUND	\$511,771
INMATE ENTERPRISE FUND	\$90,000
PARKS AND RECREATION	\$800
STATE & COUNTY ROADS FUND	\$1,095,000
PROBLEMATIC GAMBLING BEHAVIOR	\$30,000
HEALTH INSURANCE FUND	\$11,280,000
TREATMENT COURT	\$318,560
Total Revenues	\$66,117,762

Sweetwater County – FY2027 Reserve Summary

The following reserves have been approved for **Fiscal Year 2027**:

Reserve Category	Amount
General Reserve	\$37,383,187
Capital Reserve	\$1,835,445
Strategic Development	\$1,276,697
Total Reserves	\$40,495,329

NOW, BE IT RESOLVED by the Board of County Commissioners of Sweetwater County, Wyoming, that the following levies be made for the fiscal year beginning July 1, 2026, and ending June 30, 2027:

WHEREAS,

This Board has classified the following federal funding sources in accordance with applicable program requirements and intends to allocate those funds to payroll costs in the departments as listed below:

- \$3,488,465.38 in Local Assistance and Tribal Consistency Funds (Assistance Listing 21.032) is classified for payroll in the Detention Center;
- Any Schools and Roads – Grants to Counties funds (Assistance Listing 10.666) is classified for payroll in the Road and Bridge Department;
- National Wildlife Refuge Funds (Assistance Listing 15.659) and any other unanticipated federal funds are classified for payroll in the Grants Administration Department.

WHEREAS,

Additionally, the FY2027 budget assumes one month of employer health insurance costs will be funded through available Health Insurance Fund resources, resulting in a one-time reduction of General Fund expenditures.

AND WHEREAS,

After deducting all other available cash and estimated revenues, it is determined that the following amount must be raised by general taxation in order to support the County's adopted budget for FY2027:

Purpose	Tax Amount	Mill Levy
General Fund	\$27,239,224	12.000

NOW, BE IT FURTHER RESOLVED,

That the foregoing levies and classifications are hereby adopted for the 2026–2027 fiscal year ending June 30, 2027.

Dated the 30th day of June 2026.

BOARD OF COUNTY COMMISSIONERS

Sweetwater County, Wyoming

[SIGNED RESOLUTION TO PROVIDE THE REVENUES NECESSARY TO FINANCE THE BUDGET FOR FY27](#) 

ADJOURN

There being no further business to come before the Board of County Commissioners this day, the meeting was adjourned subject to the call of the Chairman. This meeting is available on the Sweetwater County YouTube channel and the County website. Links for specific meetings are available on the County website. County Clerk Office Manager/Executive Assistant to the Board of County Commissioners, Sally Shoemaker, respectfully submitted the minutes.

ATTEST:

Cynthia L. Swenson, County Clerk

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Keaton D. West, Chairman

Island Richards, Member

Absent

Taylor C. Jones, Member

Robb Slaughter, Member

Mary E. Thoman, Member



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3897
Presenters Name, Title and Name of Organization: BOCC	Exact Wording for Agenda: Approval of the July 7, 2026 Minutes
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: 2026-07-07 MINUTES WITH ATTACHMENTS.pdf	

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80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[2026-07-07 MINUTES WITH ATTACHMENTS.pdf](#)

July 7, 2026
Green River, WY

PRELIMINARY:

PLEDGE OF ALLEGIANCE

Chairman West opened the meeting with the Pledge of Allegiance.

ROLL CALL / QUORUM PRESENT

The Board of County Commissioners met this day at 9:00 a.m. in Regular Session with all Commissioners present.

APPROVAL OF THE AGENDA

Chairman West requested an amendment to the agenda to include Resolution 2026-07-CC-03, a Resolution to establish Stage 1 Fire Restrictions, and to add personnel under the executive session.

Chairman West entertained a motion to approve the agenda as amended.

Chairman West acknowledged Representative Marlene Brady in the audience.

Mary Thoman moved to approve. Island Richards seconded the motion. The motion carried.

A) PUBLIC HEARING

A.1) Transfer of Liquor License from 374 Liquor, LLC to Maverik Group, LLC

Department: County Clerk

[Cover Page](#) 

[2026-2027 LIQUOR LICENSE-MAVERIK GROUP, LLC \(2\).pdf](#) 

County Clerk Cindy Swenson appeared before the Board to present the request to transfer the liquor license from 374 Liquor, LLC to Maverik Group, LLC.

Following discussion relative to the operating hours and the application, Chairman West opened the public hearing. With no comments, the public hearing was closed.

Island Richards moved to approve the transfer of the liquor license from 374 Liquor, LLC to Maverik Group, LLC. Taylor C. Jones seconded the motion. The motion carried.

[SIGNED LIQUOR LICENSE- MAVERIK](#) 

9:10- COUNTY RESIDENT COMMENTS/CONCERNS

Chairman West opened the floor for public comment.

Randy Shipman appeared before the Board to address remarks made during the June 16, 2026, Board of County Commissioners meeting regarding the Northern Red Desert "kitchen table" stakeholder meetings. Commissioners Jones and Richards responded by sharing details and context from those collaborative conversations.

County Assessor Dave Divis appeared before the Board to report that his office is currently developing an informational flyer. The flyer will be included with upcoming tax bills to outline the specific requirements for the property tax exemption or relief application process. Assessor Divis further clarified that the distribution of the 2026 tax bills will follow standard operational procedures.

With no further comments, Chairman West closed county resident comments/concerns.

B) CONSENT AGENDA

B.1) Approval of the June 16, 2026 Minutes

Department: Board of County Commissioners

[Cover Page](#) 

[2026-06-16 MINUTES WITH ATTACHMENTS.pdf](#) 

[SIGNED 2026-6-16 MINUTES](#) 

B.2) Approval of County Vouchers/Warrants Expenditure Approval Listing (EAL) and Commissioner Report

Department: County Clerk

[Cover Page](#) 

[EAL Approval Listing Vaughn's Plumbing & Heating 7-7-2026.pdf](#) 

[COMMISSIONER REPORT 7-7-26.pdf](#) 

[EAL Approval Listing 7-7-2026.pdf](#) 

[SIGNED EAL'S- KEATON WEST ABSTAINED](#) 

[SIGNED EAL'S](#) 

B.3) **Approval of Bonds**

Department: Board of County Commissioners

[Cover Page](#) 

[BONDS.pdf](#) 

[SIGNED BONDS](#) 

B.4) **Approval of the Abates/Rebates**

Department: County Assessor

[Cover Page](#) 

[July 7th Meeting.pdf](#) 

[SIGNED ABATES REBATES](#) 

B.5) **Approval of Hospital Lab Expenditures**

Department: Board of County Commissioners

[Cover Page](#) 

[HOSPITAL LAB EXPENDITURES.pdf](#) 

[HOSPITAL LAB- 2601-PAY APP 01-26-5-29.pdf](#) 

[Groathouse check pay app 1.pdf](#) 

[SIGNED HOSPITAL LAB EXPENDITURES VOUCHER](#) 

B.6) **Request to Restaff Vacant Position in the County Attorney's Office**

Department: Human Resources

[Cover Page](#) 

[2026.06.25 Request to Restaff County Attorney.pdf](#) 

[SIGNED REQUEST TO RESTAFF DEPUTY COUNTY AND PROSECUTING ATTORNEY](#) 

B.7) **Ratification of DHS contracts with Sheriff's Office**

Department: Sheriff's Office

[Cover Page](#) 

[ICE Contract Ratification Resolution.docx](#) 

[Sweetwater Sheriff, WY TFM ICE signed 4.24.25.pdf](#) 

[Sweetwater County WSO MOA.pdf](#) 

[Sweetwater County JEM MOA - ICE Signed 3.7.25.pdf](#) 

[MOA ICE ERO - SCSO-WY- 20AUG2025 \(003\).pdf](#) 

[Signed FS_Sweetwater County Detention FY25 IGA.pdf](#) 

[Sweetwater WY MSA.pdf](#) 

[Sweetwater County - 70CDCR25FIGR00159 - 4.3.1-Award - new Task Order - 20250514 - Transportation Included.pdf](#) 

[4.3.1-Award.pdf](#) 

[SIGNED RESOLUTION 26-07-CC-01- RATIFICATION OF CONTRACTS BETWEEN SWCO SHERIFF'S OFFICE AND US DPT OF HOMELAND SECURITY, IMMIGRATION AND CUSTOMS ENFORCEMENT](#) 

B.8) **Ratify the Letter of Support for Wyoming's I-80 Green River Tunnels Repair and Safety Enhancements INFRA Grant Application**

Department: Board of County Commissioners

[Cover Page](#) 

[SWCO Letter of Support - WYDOT GR Tunnels Repair & Safety Enhancements INFRA Grant Application.pdf](#) 

Chairman West requested that the consent agenda be amended to remove the warrant from the Expenditure Approval Listing for Vaughn's Plumbing & Heating and to remove the Hospital Lab Expenditures, given his employment with the company, which also serves as a subcontractor for work on the Lab Expansion at Memorial Hospital of Sweetwater County.

Chairman West entertained a motion to approve the consent agenda as amended. ***Taylor C. Jones moved to approve. Island Richards seconded the motion.*** The motion carried.

Chairman West entertained a motion to approve the warrant to Vaughn's Plumbing & Heating.

Taylor C. Jones moved to approve. Island Richards seconded the motion. The motion carried, with Chairman West abstaining due to his employment with Vaughn's Plumbing & Heating.

Chairman West entertained a motion to approve the Hospital Lab Expenditures.

Taylor C. Jones moved to approve. Robb Slaughter seconded the motion. The motion carried, with Chairman West abstaining due to his employment with Vaughn's Plumbing & Heating, which also serves as a subcontractor for work on the Lab Expansion at Memorial Hospital of Sweetwater County.

COMMISSIONER COMMENTS

9:20- Commissioner Jones

Department: Board of County Commissioners

Commissioner Jones reported attending the Memorial Hospital Quality Committee meeting and noted that the volume of robotic-assisted surgeries performed at the facility continues to increase steadily.

Commissioner Jones shared that he participated in the Joint Powers Telecommunications Board meeting, attended the multi-agency Court Security meeting to review facility safety protocols, and attended the FY27 budget adoption meeting.

Commissioner Jones detailed the intensive final preparations for the Wyoming 250th Anniversary Trail Ride, a multi-day, organized off-road excursion. Commissioner Jones shared that he submitted official press responses to the Rock Springs Rocket-Miner newspaper regarding event routing and logistics, and that he and Pete Leibee participated in a live radio broadcast with local media host Al Harris to discuss trail parameters, safety, and community awareness. Commissioner Jones further noted that he marked the active trail system alongside Pete Leibee to ensure accurate course navigation prior to the event's launch. Concluding his report, Commissioner Jones expressed his appreciation to Senator Stacy Jones, the local volunteers, the Sweetwater Snowpokes club, and regional partners for their collaborative efforts that made the successful launch of the event possible.

9:25- Chairman West

Department: Board of County Commissioners

Chairman West reported on developments at the Young at Heart Senior Center, noting that the new Director has officially started and is currently working through updating the organization's administrative structure. Chairman West highlighted the upcoming WYO Gives Day event, emphasizing its importance for local non-profit organizations.

Chairman West reported on the Events Complex Board meeting and shared that Newmar motorhomes were on the grounds and that progress is being made on setting the silo project. Chairman West noted that the majority of his time was spent on all matters related to the fiscal year budget and expressed his appreciation for the collective teamwork displayed throughout the process.

Chairman West shared that he spoke with Lena Rux of the Ashley National Forest regarding ongoing concerns over low water levels. Chairman West explained that, due to declining water levels at the Flaming Gorge, drought and emergency dam releases are causing significant impacts on recreation. Chairman West explained that the Ashley National Forest officially closed the Anvil Draw Boat Launch, and the future accessibility of shallow-water ramps like Firehole remains highly uncertain as levels drop.

Concluding his report, Chairman West shared that the local BLM office informed that revisions to the Rock Springs Resource Management Plan are ongoing with the state and headquarters, and they intend to have another cooperators meeting prior to rolling out the public comment period sometime this summer.

9:30- Commissioner Slaughter

Department: Board of County Commissioners

Commissioner Slaughter reported his attendance at the Museum Board and Capital Committee meetings, as well as at the FY27 budget adoption meeting, where the final fiscal year budget was officially adopted.

Commissioner Slaughter shared that he watched the hearing regarding the State Board of Equalization's (SBOE) ruling on the certification of residential property tax values. Commissioner Slaughter explained that the Court found that the state had successfully made its case against the SBOE and issued a restraining order compelling the Board to exercise its authority. Commissioner Slaughter further noted that while an additional hearing had been scheduled, the Board subsequently agreed to honor the 4% property tax cap in question.

Commissioner Slaughter reported that he formally submitted the Sublette Antelope Migration Corridor Local Working Group recommendations to Governor Gordon, marking the culmination of several months of dedicated effort by the working group. He also addressed Governor Gordon's subsequent formal announcement designating the Sublette Antelope Migration Corridor, sharing that he had the privilege of speaking at the ceremony in Pinedale alongside Governor Gordon, Game and Fish Department Director Angi Bruce, and Game and Fish Commissioner Ken Roberts. Commissioner Slaughter explained that his remarks focused on the outstanding teamwork of the Local Working Group members and expressed a sincere hope that the designation will preserve the antelope population for the enjoyment of future generations.

Commissioner Slaughter shared that he attended the retirement party for Brenda Rael, expressing gratitude for her excellent years of service, and also attended the Flaming Gorge Days activities.

Commissioner Slaughter noted that administrative updates to records, including tracking new

interest deposits for the Specific Purpose tax entities and the processing of new requisitions, were successfully completed.

9:35- Commissioner Thoman

Department: Board of County Commissioners

Commissioner Thoman reported on her participation in the University of Wyoming Extension interviews and noted her attendance at the Combined Communications Joint Powers Board and Golden Hour Senior Citizens Board meetings.

Commissioner Thoman reported attending the FY27 budget adoption meeting, where the final fiscal year budget was officially adopted.

Commissioner Thoman shared that she proudly represented the Board of County Commissioners during the local 4th of July parade.

Concluding her report, Commissioner Thoman expressed her condolences to Bob Gordon's family and friends following his recent passing.

9:40- Commissioner Richards

Department: Board of County Commissioners

Commissioner Richards reported his attendance at the Airport Board meeting, where regular business was conducted and the annual budget was approved.

Commissioner Richards noted his participation in multiple weekly power coalition calls.

Commissioner Richards shared an update from Southwest Counseling Board Director John Grossnickle announcing the internal promotion of Elisa Robbins to Clinical Director, where she will oversee clinical programs, patient care quality, team development, and agency goals.

Commissioner Richards further reported on the Sweetwater County Economic Development Coalition (SEDC) Board meeting, noting that the SEDC is transitioning toward a membership-based funding model and intends to develop a new Memorandum of Understanding (MOU) with the county. Commissioner Richards clarified that the county's funding portion continues to be administered through the Land Use Department, with Land Use Director Bingham serving as the county's primary point of contact.

Commissioner Richards extended his congratulations to Brenda Rael on her retirement.

Commissioner Richards shared that he attended the Flaming Gorge Days activities and participated in the dunk tank event to benefit the SWAT Swim Club.

Commissioner Richards reported attending the budget meeting to officially adopt the Fiscal Year 2027 county budget. Following the budget adoption, Commissioner Richards participated in the multi-day, 500-mile Wyoming 250th Anniversary Trail Ride and extended his appreciation to all

involved for the collaborative coordination.

Commissioner Richards provided an overview of his upcoming schedule.

C) ACTION/PRESENTATION ITEMS

C.0) Resolution 2026-07-CC-03, a Resolution Order to Establish Stage 1 Fire Restrictions

Sweetwater County Fire Warden Alan Adams appeared before the Board to present Resolution 2026-07-CC-03, a Resolution Order to Establish Stage 1 Fire Restrictions.

Following discussion outlining the process and the request for weekly condition updates, Chairman West entertained a motion to approve Resolution 2026-07-CC-03, a Resolution Ordering and Establishing Stage 1 Fire Restrictions, to be effective beginning on Friday, July 10, 2026, and ending on August 7, 2026, unless temporarily lifted or reimposed by the Board of County Commissioners.

Mary Thoman moved to approve. Taylor C. Jones seconded the motion. The motion carried.

[SIGNED RESOLUTION 2026-07-CC-03- ORDER ESTABLISHING STAGE 1 FIRE RESTRICTION](#) 

C.1) [9:45- Annual Compensation Agreement between the University of Wyoming and the Sweetwater County Board of County Commissioners](#)

Department: Board of County Commissioners

[Cover Page](#) 

[Sweetwater_Bynum_Annual_Compensation_Agreement_FY27.pdf](#) 

Chairman West presented the Annual Compensation Agreement between the University of Wyoming and the Sweetwater County Board of County Commissioners.

Mary Thoman moved to approve the Annual Compensation Agreement between the University of Wyoming and the Sweetwater County Board of County Commissioners for the Extension Office for the horticulture position. Robb Slaughter seconded the motion. The motion carried.

[SIGNED ANNUAL COMPENSATION AGREEMENT BETWEEN THE UNIVERSITY OF WYOMING AND THE BOCC](#) 

C.2) [9:50- Award of the FY2026 Sweetwater County Library Parking Lot Project](#)

Department: Public Works

[Cover Page](#) 

[Letter to Commissioners to award FY26 Library Parking Lot.pdf](#) 

[Notice of Award_FY2026 Sweetwater County Library Parking Lot Project.pdf](#) 

Public Works Assistant Director Andy Hooton appeared before the Board and presented the bid results for the FY26 Sweetwater County Library Parking Lot Project, which was held on June 18, 2026.

Chairman West entertained a motion to award the FY2026 Sweetwater County Library Parking Lot Project to R&D Sweeping & Asphalt Maintenance, LC, in the sum of \$102,062.01 and authorize the Chairman to sign all necessary project documents.

Mary Thoman moved to approve. Island Richards seconded the motion. The motion carried.

[SIGNED FY2026 SWCO LIBRARY PARKING LOT PROJECT NOTICE OF AWARD](#) 

C.3) **[9:55- Resolution #2026-07-CC-02, a Resolution Authorizing the Appointment of a Special Prosecutor](#)**

Department: Attorney's Office

[Cover Page](#) 

[Resolution -Sublette County 6.29.26.docx](#) 

Chief Deputy County Attorney John DeLeon appeared before the Board to present Resolution 2026-07-CC-02, a Resolution Authorizing the Appointment of a Special Prosecutor.

Following discussion, Chairman West entertained a motion to approve Resolution #2026-07-CC-02, a Resolution Authorizing the Appointment of a Special Prosecutor.

Island Richards moved to approve. Taylor C. Jones seconded the motion. The motion carried.

[SIGNED RESOLUTION 2026-07-CC-02- AUTHORIZING THE APPOINTMENT OF A SPECIAL PROSECUTOR](#) 

C.4) **[10:00- Amendment Four to FY20 Wyoming Commercial Air Service Improvement Plan Cooperative Agreement](#)**

Department: Attorney's Office

[Cover Page](#) 

[AMENDMENT Four \(Changes\) FY20 Air Service COOPERATIVE AGREEMENT.docx](#) 

[Amendment Four FY20 Air Service Cooperative Agreement with Attachment 1.pdf](#) 

[SIGNED AMENDMENT FOUR TO THE MEMORANDUM OF UNDERSTANDING BETWEEN THE WYOMING DPT OF TRANSPORTATION AND THE SWEETWATER COUNTY COM.pdf](#) 

Southwest Wyoming Regional Airport Director Devon Brubaker appeared before the Board to present Amendment Four to the FY20 Wyoming Commercial Air Service Improvement Plan Cooperative Agreement.

Mr. Brubaker explained that the cooperative agreement reopens annually to evaluate shifting industry rates and charges due to year-to-year volatility in the airline industry and highlighted the following key financial adjustments within the amendment:

- The block hour rate decreased from the previously projected \$4,837 down to \$4,767.
- The total "Not to Exceed" (NTE) cap increased from \$4,799,169 to \$4,979,991.

Mr. Brubaker noted that multiple variables dictate the final NTE calculation, including forecasted passenger loads, forecasted average airfares, and fuel costs per gallon, and clarified that while the base block hour rate decreased during negotiations, higher overall fuel costs drove the increase in the total NTE cap.

Mr. Brubaker reminded the Board that the county is billed only for actual operational costs, minus realized revenues, up to the NTE cap, and should market performance exceed forecasts (via lower fuel prices, higher passenger volume, or higher average fares), the county pays less; if performance falls below forecasts, the county's financial exposure remains strictly capped at its local 40% share of the NTE amount.

Mr. Brubaker shared that rates align with the figures previously reviewed during the county's budgeting process, and noted that all three participating funding entities have already allocated their respective portions of the NTE within their active fiscal year 2027 budgets.

Chairman West entertained a motion to approve Amendment Four to the FY2020 Wyoming Commercial Air Service Improvement Plan Cooperative Agreement and authorize the Chairman to sign, as well as Attachment One, which is Amendment Five to the Memorandum of Understanding between the Wyoming Department of Transportation and Sweetwater County Board of County Commissioners, and authorize the Chairman to sign.

Island Richards moved to approve. Mary Thoman seconded the motion. The motion carried.

[SIGNED AMENDMENT FOUR TO THE FY2020 WYOMING COMMERCIAL AIR SERVICE IMPROVEMENT PLAN COOPERATIVE AGREEMENT](#) 

C.5) [10:10- Sweetwater Events Complex and Wyoming Horse Racing Usage Agreement](#)

Department: Other

[Cover Page](#) 

[WHR SEC Lease Agreement 2031-2035.pdf](#) 

Sweetwater Events Complex CEO Kandi Pendleton appeared before the Board to present the Usage Agreement for Pari-Mutuel Racing Facilities. Also present to express appreciation for the continued relationship and support were Wyoming Horse Racing Representatives Peter Legoria, Eugene Joyce, and Sean Beirne.

Following discussion regarding the working relationship and predictable revenue stream, Chairman West entertained a motion to approve the Sweetwater Events Complex and Wyoming Horse Racing Usage Agreement and to authorize the Chairman to sign.

Taylor C. Jones moved to approve. Robb Slaughter seconded the motion. The motion carried.

[SIGNED SWEETWATER EVENTS COMPLEX USAGE AGREEMENT PARI-MUTUEL RACING FACILITIES](#) 

C.6) [10:15- Break](#)

Department: Board of County Commissioners

Chairman West called for a ten-minute break.

C.7) [10:25- Information regarding Election Machines](#)

Department: Board of County Commissioners

[Cover Page](#) 

[ELECTION Attachments A - D Commish June 2026.pdf](#) 

Laura McKee appeared before the Board to provide information regarding election equipment and software specifications. Ms. McKee noted that the Election Systems & Software (ES&S) 6.0.6.0 voting system includes updated Microsoft Operating System images, crucial security updates for critical vulnerabilities (such as the "PrintNightmare" exploit), and active antivirus definitions.

Ms. McKee explained that an Engineering Change Order (ECO) specifically addressing CVE-2021-34527, a vulnerability impacting Election Voting Systems (EVS) and connected Windows environments, was formally approved in June 2022 to secure the infrastructure. Ms. McKee further explained that the system's hardware configuration consists of Dell servers and workstations, integrated Trusted Platform Module (TPM) security chips, and designated USB flash drives.

Ms. McKee concluded by noting that certification standards state that any unapproved modifications will void Election Assistance Commission (EAC) approval, that no additional equipment warranties exist beyond the standard purchase agreements, and that hand counting ballots should be required.

Following the presentation, the Board addressed the logistical challenges and the statistically higher rates of human error inherent in hand-counting ballots compared to certified, auditable optical-scan machinery.

The Commission expressed appreciation for the presentation.

C.8) [10:40- Quarterly Ambulance Update](#)

Department: Board of County Commissioners

[Cover Page](#) 

[CRHD Meeting Request with handout 7.7.26.pdf](#) 

Castle Rock Hospital District (CRHD) Chief Executive Officer Bailie Dockter appeared before the Board to present the quarterly ambulance update. Also present representing CRHD were Chief Financial Officer Todd Toolson, Human Resources & Interim Ambulance Director Jenny Magagna, and Board Members Patsy Sorenson and Reed Robbins.

Ms. Dockter detailed current operational services and outlined a net operational loss due to revenue shortfalls, driven primarily by declines in transport and emergency calls. She explained that significant contractual adjustments, coupled with rigid operational expenditures for staff benefits and equipment depreciation, caused total expenses to slightly exceed the projected budget.

Ms. Dockter highlighted upcoming community events for which Castle Rock Ambulance will provide on-standby medical services. Ms. Dockter also provided a progress report on the construction phase of the new ambulance barn in Rock Springs and shared that the district is in the process of purchasing a new ambulance.

Ms. Dockter explained that CRHD continues to actively apply for grants through the Rural Health Transformation Fund to support ongoing operations.

Ms. Dockter noted that, overall, the fiscal year progressed well and outlined strategic steps to attract additional personnel to stabilize staffing levels and move toward a more regionalized emergency medical services approach.

Following the presentation, the Commission expressed its appreciation for the quarterly update. The Board noted that with one year remaining on the current county subsidy contract, it is time to initiate collaborative conversations regarding the long-term future and sustainability of the ambulance service.

The Commission revisited the specific application and compliance requirements for the Rural Health Transformation Fund. Additionally, the Board requested that CRHD provide expanded, data-driven metrics within the meeting packet for all future quarterly updates.

[11:00- EXECUTIVE SESSION](#)

[1. Potential Litigation](#)

[2. Personnel](#)

Chairman West entertained a motion to enter into executive session for potential litigation and personnel purposes.

Island Richards so moved. Taylor C. Jones seconded the motion. The motion carried.

Chairman West entertained a motion to exit the executive session and reconvene the meeting, and explained that no action was required.

Mary Thoman so moved. Taylor C. Jones seconded the motion. The motion carried.

ADJOURN

There being no further business to come before the Board of County Commissioners this day, the meeting was adjourned subject to the call of the Chairman. This meeting is available on the Sweetwater County YouTube channel and the County website. Links for specific meetings are available on the County website. County Clerk Office Manager/Executive Assistant to the Board of County Commissioners, Sally Shoemaker, respectfully submitted the minutes.

ATTEST:

Cynthia L. Swenson, County Clerk

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Keaton D. West, Chairman

Island Richards, Member

Taylor C. Jones, Member

Robb Slaughter, Member

Mary E. Thoman, Member



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3754
Presenters Name, Title and Name of Organization: Accounting	Exact Wording for Agenda: Approval of County Vouchers/Warrants Expenditure Approval Listing (EAL) and Commissioner Report
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 Minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: COMMISSIONER REPORT 7-21-20226.pdf EAL Approval Listing 7-21-26.pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov
*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
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- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[COMMISSIONER REPORT 7-21-20226.pdf](#)

[EAL Approval Listing 7-21-26.pdf](#)

7/9/2026

WARRANT NO.s	PAYEE	DESCRIPTION	AMOUNT
50465-50707 & 130853-130864	EMPLOYEES AND PAYROLL VENDORS	PAYROLL RUN	1,748,076.67
50708-50710 & 130865	EMPLOYEES AND PAYROLL VENDORS	PAYROLL RUN	29,393.64
50711	CASTLE ROCK HOSPITAL DISTRICT	BUDGET ALLOCATION	141,666.66
50712	LUMELIGHT	CLAIMS AUDIT	14,825.00
50713	OPTUM BANK 76411492	CONTRIBUTIONS	8,366.44
50714	REILLY, CARLA SULLIVAN	FEES	1,010.42
50715	SOUTHWEST COUNSELING/MENTAL HEALTH	BUDGET ALLOCATION	32,650.00
50716	SOUTHWEST WYOMING REGIONAL AIRPORT	BUDGET ALLOCATION	187,227.50
50717	STAFFORD, NANCY	MILEAGE	854.05
50718	SWCO CONSERVATION DISTRICT	BUDGET ALLOCATION	8,377.92
50719	SWEETWATER COUNTY HEALTH BOARD	BUDGET ALLOCATION	24,429.08
50720	SWEETWATER COUNTY LIBRARY	BUDGET ALLOCATION	267,363.17
50721	WEX BANK	FUEL	19,173.76
130866	AT&T MOBILITY	PHONE BILL	49.66
130867	BETTER BUSINESS PLANNING INC	FEES	1,217.34
130868	BOB BARKER COMPANY INC	COMMISSARY	4,083.98
130869	BRIDGER VALLEY ELECTRIC ASSN	UTILITIES	267.10
130870	BYNUM, ALEISHA	MILEAGE	324.80
130871	CARVER M.D., JOHN D	AUTOPSY	1,350.00
130872	CENTURYLINK	PHONE BILL	1,631.86
130873	CENTURYLINK	PHONE BILL	65.60
130874	CITY OF GREEN RIVER	UTILITIES	1,842.45
130875	DANA SAFETY SUPPLY	BELTS/PANTS	358.93
130876	DIVIS, DAVID S	TRAVEL	559.19
130877	ECOLAB INC	SUPPLIES	15.09
130878	ENBRIDGE GAS UT WY ID	UTILITIES	12.86
130879	GREEN RIVER STAR	ADS	4,800.00
130880	INFINITY POWER & CONTROLS, LLC	BATTERIES	548.58
130881	J M ELECTRICAL INC	LABOR	3,500.00
130882	K-PACK PHARMACY	INMATE RX	2,980.29
130883	LEGEND SERVICES PRESSURE CONTROL INC	SERVICES	3,560.50
130884	LR COMMUNICATIONS INC	INTERNET	64.95
130885	MADSEN CONSTRUCTION INC	CONTRACT	174,883.81
130886	NATIONAL RECREATION & PARK ASSOCIATION	DUES	735.00
130887	OLDCASTLE INC	PARTS	310.00
130888	REAL KLEEN JANITORIAL	CLEANERS	220.50
130889	ROCK SPRINGS MUNICIPAL UTILITY	UTILITIES	9,570.11
130890	ROCKY MTN POWER	UTILITIES	22,609.03
130891	VICTORIA SCHOFIELD ATTORNEY	FEES	1,072.50
130892	SCHUMACHER LAW P.C.	FEES	692.50
130893	SHADOW MOUNTAIN WATER OF WYOMING INC	RENTAL	79.75
130894	SIDELINE COLLECTIONS INC	RANDOMS	375.00

Ran for Dates: 6/29/2026 to 7/9/2026

130895	SLAUGHTER, ROBERT D	MILEAGE	188.50
130896	STATE OF WYOMING	SUBSCRIPTION	125.63
130897	STRODE FORENSICS PLLC	AUTOPSY	1,110.00
130898	SWEETWATER COUNTY FAIR	BUDGET ALLOCATION	152,627.33
130899	SWEETWATER COUNTY MUSEUM	BUDGET ALLOCATION	28,557.50
130900	TEGELER & ASSOCIATES	BOND	500.00
130901	THE MASTER'S TOUCH LLC	POSTAGE	13,978.58
130902	TOWN OF WAMSUTTER	FIRE PROTECTION	5,100.00
130903	TUBBS MD LLC, KENNON C	INMATE MEDICAL	6,523.00
130904	TYLER TECHNOLOGIES INC	MAINTENANCE	115,469.04
130905	U S POSTAL SERVICE (NEOPOST POSTAGE-ON CALL)	POSTAGE	6,000.00
130906	UNIFORMS 2 GEAR INC	NAMEBAR/KEY HOLDERS	68.45
130907	UNION TELEPHONE COMPANY INC	PHONE BILL	52.17
130908	VASE FUNERAL CHAPELS & CREMATORY	SERVICES	1,500.00
130909	VONAGE BUSINESS	PHONE BILL	1,186.03
130910	W A R M PROPERTY INSURANCE POOL	ASSESSMENT	449,887.27
130911	WEST SIDE SEWER DISTRICT	UTILITIES	7,176.00
130912	WESTFAX INC	FAXES	154.30
130913	WEVOLVE COUNSELING, LLC	SERVICES	1,000.00
130914	WYOMING COUNTY COMMISSIONERS ASSOCIATION	DUES	33,178.00
130915	WYOMING LAW ENFORCEMENT ACADEMY - WLEA	TRAINING/AMMO/CLOTHING	1,944.25
130916	WYOMING WASTE SERVICES	UTILITIES	1,127.54
		GRAND TOTAL:	3,548,649.28

	DATE	AMOUNT	WARRANT #'S	ADVICE #'S
EAL	7/9/2026	1,771,178.97	50711-50721	130866-130916
EAL				
EAL				
EAL				
EAL				
			Check #	Advice #
Payroll Run		1,748,076.67	130853-130864	50465-50707
Payroll Run		29,393.64	130865	50708-50710
Payroll Run				
Payroll Run				
TOTAL AMOUNT		\$3,548,649.28		

Vouchers in the above amount are hereby approved and ordered paid this date of 7/21/2026

Keaton D. West, Chairman

Taylor C. Jones, County Commissioner

Island Richards, County Commissioner

Robert D. Slaughter, County Commissioner

Attest:

County Clerk

Mary E. Thoman, County Commissioner



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3897
Presenters Name, Title and Name of Organization: BOCC	Exact Wording for Agenda: Approval of the Bonds
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 Min	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: BONDS.pdf	

INSTRUCTIONS:

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The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[BONDS.pdf](#)

Approval of Bonds
OFFICIAL BOND AND OATH
7-21-2026

<u>NAME</u>	<u>OFFICE</u>	<u>BOND AMOUNT</u>
JOSEPHINE ANN ZAKOTNIK	EDEN-FARSON CEMETARY DISTRICT	\$5,000.00

THE BOARD OF COUNTY COMMISSIONERS
FOR SWEETWATER COUNTY, WYOMING

Keaton D. West, Chairman

Taylor C. Jones, Commissioner

ATTEST:

Island Richards, Commissioner

Cynthia L. Swenson, County Clerk

Robert D. Slaughter, Commissioner

Mary E. Thoman, Commissioner

Wyoming



Western Surety Company

OFFICIAL BOND AND OATH

KNOW ALL PERSONS BY THESE PRESENTS:

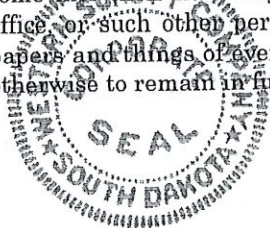
Bond No. 51948902

That we Josephine Ann Zakotnik,
of Farson, Wyoming, as Principal, and WESTERN SURETY COMPANY,
a corporation duly licensed to do business in the State of Wyoming, as Surety, are held and firmly bound
unto Eden-Farson Cemetary District, the State of Wyoming, in the penal
sum of Five Thousand and 00/100 DOLLARS (\$ 5,000.00),
to which payment well and truly to be made, we bind ourselves and our legal representatives, jointly and
severally, firmly by these presents.

Dated this 29th day of May, 2026.

THE CONDITION OF THE ABOVE OBLIGATION IS SUCH, That whereas, the above bounden
Principal was duly elected or appointed to the office of Treasurer
in the Eden-Farson Cemetary District,
and State aforesaid for the term beginning July 1st, 2026, and ending
July 1st, 2027.

NOW THEREFORE, If the above bounden Principal and their deputies shall faithfully, honestly and
impartially perform all the duties of their said office of Treasurer
as is or may be prescribed by law, and shall with all reasonable skill, diligence, good faith and honesty safely
keep and be responsible for all funds coming into the hands of such officer by virtue of their office; and pay
over without delay to the person or persons authorized by law to receive the same, all moneys which may
come into their hands by virtue of their said office; and shall well and truly deliver to their successor in
office, or such other person or persons as are authorized by law to receive the same, all moneys, books,
papers and things of every kind and nature held by them as such officer, the above obligation shall be void,
otherwise to remain in full force and effect.



Josephine Ann Zakotnik
Principal

WESTERN SURETY COMPANY

By Larry Kasten
Larry Kasten, Vice President

ACKNOWLEDGMENT OF SURETY
(Corporate Officer)

STATE OF SOUTH DAKOTA }
County of Minnehaha } ss

On this 29th day of May, 2026, before me, appeared

Larry Kasten to me personally known, being by me sworn, and did say that he is the aforesaid officer of WESTERN SURETY COMPANY, and that the seal affixed to said instrument is the corporate seal of said corporation, and that said instrument was signed and sealed on behalf of said corporation by authority of its Board of Directors, and said officer acknowledged said instrument to be the free act and deed of said corporation.

S. PETRIK
NOTARY PUBLIC
SOUTH DAKOTA
My Commission Expires August 11, 2028

S. Petrik
Notary Public

OATH OF OFFICE

I do solemnly swear (or affirm) that I will support, obey and defend the constitution of the United States, and the constitution of the state of Wyoming; that I have not knowingly violated any law related to my election or appointment, or caused it to be done by others; and that I will discharge the duties of my office with fidelity.

Josephine Ann Zakotnik

State of Wyoming }
County of Sweetwater } ss

GAIL JOHNSON
NOTARY PUBLIC
STATE OF WYOMING
COMMISSION ID: 154792
MY COMMISSION EXPIRES: 11/30/2030

This Oath of Office was subscribed and sworn to before me by Josephine Ann Zakotnik
on this 2nd day of July, 2026.
My commission expires:

Gail Johnson
Notary Public, Wyoming

ACKNOWLEDGMENT OF PRINCIPAL

THE STATE OF WYOMING }
County of Sweetwater } ss

On this 2nd day of July, 2026, before me, personally appeared

Josephine Ann Zakotnik, to me known to be the person described in and who executed the foregoing instrument as Principal, and acknowledged that the same was executed as her free act and deed.

My commission expires

November 30, 2030

Gail Johnson
Notary Public, Wyoming

GAIL JOHNSON
NOTARY PUBLIC
STATE OF WYOMING
COMMISSION ID: 154792
MY COMMISSION EXPIRES: 11/30/2030



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3897
Presenters Name, Title and Name of Organization: BOCC	Exact Wording for Agenda: Approval of the Monthly Reports
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: MONTHLY REPORTS.pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov
*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
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80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[MONTHLY REPORTS.pdf](#)

Approval of Monthly Reports
7-21-26

1. **COUNTY CLERK**
2. **CLERK OF DISTRICT COURT**
3. **SHERIFF'S OFFICE**

THE BOARD OF COUNTY COMMISSIONERS
 FOR SWEETWATER COUNTY, WYOMING

 Keaton D. West, Chairman

 Taylor C. Jones, Commissioner

 Island Richards, Commissioner

ATTEST:

 Cynthia L. Swenson, County Clerk

 Robert D. Slaughter, Commissioner

 Mary E. Thoman, Commissioner

MONTHLY STATEMENT

Statement of the Earnings of Collections of CYNTHIA L LANE COUNTY CLERK within and for the County of Sweetwater, State of Wyoming, for the month ending June 2026 and reported to the Board of County Commissioners of said County.

COUNTY CLERK			
Recording Fees		25,155.00	
Marriage Licenses		960.00	
Chattel Mortgages		9,703.00	
Motor Certificates of Title	(1613 /TITLES)	24,195.00	22,582.00
iDoc Market Subscriptions		1,977.00	
Miscellaneous Receipts		623.25	
Total Receipts			62,613.25
	Abandoned Vehicle		(1,613.00)
			61,000.25

STATE OF WYOMING)
) ss.
 COUNTY OF SWEETWATER)

I hereby certify that the above is a true and correct statement of the earnings of my office, or of moneys collected by me as such officer during the month above mentioned, and that the same has been by me paid into the County Treasury.

Witness my hand and seal this 01 day of July 2026

/s/ Cynthia L. Lane

COUNTY CLERK

Donna Wardell

DEPUTY

Examined and approved by the Board of County Commissioners, this _____ day of _____

Chairman

Commissioner

Commissioner



Monthly Statement

Statement of the earnings or collections of **Amanda L. Chetterbock** as **Clerk of District Court** within and for the county of Sweetwater, state of Wyoming, for the month ending:
June 30, 2026

Reported to the Board of County Commissioners of said County.

<u>CIVIL FEES</u>	\$8,564.30
Code: DC	
<u>BOND FORFEITED</u>	\$0.00
Code: FO	
<u>CRIMINAL FINES/COSTS</u>	\$1,250.00
Code: CF	
TOTAL EARNINGS	\$9,814.30
TOTAL REMITTED.....	\$9,814.30

Clerk of District Court Check # 26156

STATE OF WYOMING
COUNTY OF SWEETWATER

I hereby certify that the above is a true and correct statement of the earnings of my office, or of moneys collected by me as such officer, during the month above mentioned, and that the same has been by me paid into the county treasury

Witness, my hand and seal this 1st day of July, 2026.


Amanda L. Chetterbock, Clerk of District Court



Monthly Statement

Statement of the earnings or collections of **Rich Fischer** as **Sheriff** within and for the county of Sweetwater, state of Wyoming, for the month ending:

June 2026

Reported to the Board of County Commissioners of said County.

SHERIFF CIVIL FEES-paid by Cash, Money Order or Cashier's
Check.....\$5993.31

SHERIFF CIVIL FEES-paid by cc/Forte \$242.50

TOTAL REMITTED.....\$6235.81

STATE OF WYOMING
COUNTY OF SWEETWATER

I hereby certify that the above is a true and correct statement of the earnings of my office, or of moneys collected by me as such officer, during the month above mentioned, and that the same has been by me paid into the county treasury

Witness, my hand and seal this June 30th, 2026.



Rich Fischer, Sheriff



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: sanchezj@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: Joe Sanchez, Lead Appraisal Technician, Assessor	Exact Wording for Agenda: Approval of Abates-Rebates
Preference of Placement on Agenda & Amount of Time Requested for Presentation: N/A	Will there be handouts? (If yes, include with meeting request form) No
Will handouts require SIGNATURES? No SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: July 21st Meeting.pdf	

INSTRUCTIONS:

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Meeting Room #115

Green River, Wyoming

[July 21st Meeting.pdf](#)

Authorization for Abate/Rebate of Ad Valorem Taxes								
JULY 21ST, 2026 MEETING								
NOVC	TAXPAYER	ACCOUNT	TAX DIST	VALUATION	TAX YEAR	ADJUSTMENTS	REASON	A/R NUMBER
2026-0357	WAPITI OPERATING, LLC	155325	102	-242	2025	-18.17	DOR	71226
2026-0357	WAPITI OPERATING, LLC	154929	200	-127,934	2025	-8,455.67	DOR	71326
2026-0414	CONTANGO RESOURCES INC.	156151	101	-1,129,103	2023	-76,111.70	DOR	71426
			TOTAL	-1,257,279		-84,585.54		

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Keaton D. West, Chariman

Taylor C Jones, Memeber

Island Richards, Member

Robert D. Slaughter, Member

Mary E. Thoman, Member

ATTEST:

Cynthia L. Swenson, County Clerk



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3897
Presenters Name, Title and Name of Organization: BOCC	Exact Wording for Agenda: 10:15- Solid Waste Disposal District- Eden Valley Board Appointment
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? No SHOULD THE ITEM BE MARKED CONFIDENTIAL? Yes	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information: Due to the expiring term of Mike Boodleman, one 3-year term on the Solid Waste Disposal District Eden Valley Board is vacant.	
Attachments:	

INSTRUCTIONS:

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Meeting Room #115
Green River, Wyoming



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: (307) 872-3888 marchalk@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: County Grants Manager Krisena Marchal	Exact Wording for Agenda: 10:20- Acceptance of the FY 2027 Services to Victims of Crime Grant Contract
Preference of Placement on Agenda & Amount of Time Requested for Presentation: Morning, 5 minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? No SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information: Please see executive summary.	
Attachments: BOCC 7-21-26 VICTIM WITNESS GRANT SUMMARY.pdf	

INSTRUCTIONS:

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Green River, Wyoming

[BOCC 7-21-26 VICTIM WITNESS GRANT SUMMARY.pdf](#)

To: Sweetwater County Board of County Commissioners
From: Krisena Marchal, Grants Manager
Date: July 21, 2026
Subject: Acceptance of the FY 2027 Services to Victims of Crime Grant Contract

Executive Summary:

Sweetwater County was awarded \$104,093 in federal and state funding from the Wyoming Division of Victim Services under the Office of the Attorney General.

The purpose of the funding is to provide services to victims of crime in the community:

- Provide support and community referrals
- Assist victims with filing for compensation
- Provide information about cases and court procedures
- Accompany witnesses and victims to court
- Act as a liaison with the criminal justice system

The grant will be used to pay for two part-time victim witness coordinator positions who work with one other victim witness coordinator in the County Attorney's Office. Together, these employees enforce Wyoming's Bill of Rights in Sweetwater County.

FY 2027 VICTIMS OF CRIME PROJECT BUDGET			
EXPENSES	FUNDING		TOTAL BUDGET
	Grant Award	County Overage	
FY 2027 Payroll 2 Victim Witness Coordinators • Grade 16 @ ~35 hrs/week • Grade 15 @ ~26 hrs/week	104,093	26,673	\$130,766
Software VS Tracking required for victim reporting	0	1,500	\$1,500
TOTAL	\$104,093 (79%)	\$28,173 (21%)	\$132,266

Staff Notes:

The County's overage amount was included in the FY 2027 Grant Projects Budget which included a 5% increase to health insurance. The payroll information was provided by Human Resources. Any cost savings will go back to the County. Other operational costs are part of the Attorney Office's regular budget.

There are no documents for the Chairman to sign.

Attachment:

1. FY 2027 Contract and Assurances (already signed by County Attorney Daniel Erramouspe)

Recommendation:

Move to accept the Fiscal Year 2027 Services to Victims of Crime Grant Contract.

**FISCAL YEAR 2027 CONTRACT
FOR SERVICES TO VICTIMS OF CRIME BETWEEN
THE STATE OF WYOMING, OFFICE OF THE ATTORNEY GENERAL, DIVISION
OF VICTIM SERVICES
AND
SWEETWATER COUNTY ATTORNEY'S OFFICE**

1. **Parties.** The parties to this Contract are the State of Wyoming, Office of the Attorney General, Division of Victim Services (Division), whose address is 320 West 25th Street, 2nd Floor, Cheyenne, WY 82002, and Sweetwater County Attorney's Office (Contractor), whose address is 80 W. Flaming Gorge Way, Ste. 21 Green River, WY 82935. The Contractor's SAM Unique Entity ID is WV9GN21T4C53, the EIN is 836000126, and Vendor Code is VC*86876.
2. **Purpose of Contract.** The purpose of this Contract is to set forth the terms and conditions by which the Contractor shall provide services to victims of all crime as defined by and in accordance with applicable federal law, state law, the applicable Rules and Regulations of the Division of Victim Services, incorporated herein, and the approved strategic plan, grant proposals, and budgets on file at the Division. This Contract does not include funding for Research and Development (R&D) projects.
3. **Term of Contract.** This Contract is effective when all parties have executed it (Effective Date). The Performance Period of this Contract is from July 1, 2026 through June 30, 2027. All services shall be completed during this term.
4. **Reimbursement.**
 - A. **Reimbursement.** The Division agrees to reimburse Contractor for services described in this Contract. The total reimbursement under this Contract shall not exceed one hundred four thousand ninety-three dollars and no cents (\$104,093.00). No reimbursement shall be made prior to the Effective Date of this Contract. The amount payable under this Contract is allocated as follows:
 - (i) The following federal funds must support the project as outlined in the SFY2027/2028 approved grant proposal:
 - (a) VOCA: Twenty-six thousand dollars and no cents (\$26,000.00). Funds will be paid from the 15POVC-25-GG-00383-ASSI VOCA-Assistance grant, Department of Justice, Office for Victims of Crime, ALN # 16.575 (federal award date: 9/17/2025).
 - (ii) The following FY2027 state funds must support the project as outlined in the SFY2027/2028 approved grant proposal:

- (a) State Victim Witness funds: Fifty-four thousand twenty-four dollars and no cents (\$54,024.00).
- (b) State Surcharge funds: Twenty-four thousand sixty-nine dollars and no cents (\$24,069.00).

B. Suspension of Reimbursement.

- (i) If the Contractor is not in compliance with the Division's Rules and Regulations (see Sections 5(B) and 6(B) below) the Division may withhold reimbursement for the month following the noncompliance and suspend future reimbursements until the Contractor is in compliance.

C. Reporting. By July 31st of each year that this Contract is in effect, Contractor shall provide the Division with summary information on all expenses and anticipated expenses incurred between July 1st of the prior year through June 30th of the current year. Failure to provide the Division with this expense information by July 31st may result in the Division failing to reimburse Contractor for any expenses that were incurred prior to June 30th, but not reported.

5. Responsibilities of Contractor.

- A. Performance Accountability.** The Contractor's governing body shall be accountable for the performance of this Contract.
- B. Compliance with Rules.** The Contractor shall comply with all applicable Rules and Regulations of the Division of Victim Services. In the event the Contractor's monthly statistics, fiscal, progress, or project summary reports are thirty (30) days late, the Division may withhold further reimbursements until all reports are made current. The Contractor agrees to adhere to all federal grant requirements and the assurances set forth in Attachment B, Certified Assurances & Special Conditions, which is attached to and incorporated into this Contract and is being signed simultaneously with this Contract.
- C. Management Information System.** The Contractor shall submit to the Division, by electronic submission, accurate information on each client in the manner required by Division.
- D. Financial Records and Reports.** The Contractor shall maintain accounting records and documents in accordance with generally accepted accounting procedures and provide financial reports as may be requested by the Division.
- E. Monitoring and Evaluation.** The Contractor agrees to monitoring and evaluation of programs, services, and Contract compliance, to be conducted by staff of the

Division in accordance with the applicable Rules and Regulations of the Division of Victim Services.

- F. **Corrective Action.** The Contractor shall take corrective action in a timely manner to remedy any deficiencies affecting compliance with this Contract and/or to remedy any deficiencies affecting substantial compliance with the applicable Rules and Regulations of the Division of Victim Services.
- G. **Minutes.** Contractor shall keep copies of minutes of board of directors' meetings on file at its office and make them available for review upon request of the Division.
- H. **Required Meetings.** The Contractor shall ensure representation at grantee meetings, and at management and program trainings convened by or on behalf of the Division.

6. **Responsibilities of the Division.**

- A. **Consultation.** The Division shall consult with and advise the Contractor, as necessary, to enable the Contractor to complete its duties under this Contract.
- B. **Withholding Payments.** The Division shall reimburse the Contractor, upon receipt of monthly invoices, unless the Contractor has failed to meet the requirements of this Contract, at which time the Division shall notify the applicable president or chairman of the board or administering agency designee of such noncompliance. Failure to take prompt corrective action may result in the Division withholding reimbursements until appropriate corrective action has been taken. If such action is not taken, the Contract may be terminated in accordance with the applicable Rules and Regulations of the Division of Victim Services or the Termination provision of this Contract.
- C. **Monitoring and Evaluation.** The Division shall monitor and evaluate the Contractor's compliance with the conditions and provisions set forth in this Contract.

7. **Special Provisions.**

- A. **Source of Funds.** Funds for this Contract are a combination of federal funds made available by the U.S. Congress and state general funds made available by the Wyoming Legislature. There is no obligation on the part of the State of Wyoming to continue these services with state general funds or with federal funds.
- B. **Interest on Funds.** The Contractor may not draw interest payments on funds made available through this Contract.

- C. Prohibited Uses of Funds.** Funds made available to the Contractor through this Contract shall be used for purposes specified in the Contract and not for any other purpose. Prohibited uses of funds include, but are not limited to:
- (i) Capital construction projects or the purchase of buildings or other long-term capital investments unless otherwise specifically provided herein; and
 - (ii) Payment of expenses for lobbying for state and federal funds, including travel, per diem, telephone, printing, or services of a lobbyist.
- D. Full-time County Offices.** The Contractor agrees to maintain a full-time office in Sweetwater County in accordance with the Contractor's application for funding.
- E. Prohibition of Subcontracting.** The Contractor shall not subcontract any services purchased under this Contract without prior written approval of the Division. If the Division approves a subcontract arrangement by the Contractor, the Contractor shall retain full program and fiscal responsibility for subcontracted services.
- F. No Finder's Fees.** No finder's fee, employment agency fee, or other such fee related to the procurement of this Contract shall be paid by either party.
- G. Nondiscrimination.** The Contractor shall comply with the Civil Rights Act of 1964, the Wyoming Fair Employment Practices Act (Wyo. Stat. § 27-9-105, *et seq.*), the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, *et seq.*, and the Age Discrimination Act of 1975 and any properly promulgated rules and regulations thereto and shall not discriminate against any individual on the grounds of age, sex, color, race, religion, national origin, or disability in connection with the performance under this Contract.
- H. Limitations on Lobbying Activities.** By signing this Contract, Contractor certifies and agrees that, in accordance with P.L. 101-121, payments made from a federal grant shall not be utilized by Contractor or its subcontractors in connection with lobbying member(s) of Congress, or any federal agency in connection with the award of a federal grant, contract, cooperative agreement, or loan.
- I. Monitoring Activities.** The Division shall have the right to monitor all activities related to this Contract that are performed by Contractor or its subcontractors. This shall include, but not be limited to, the right to make site inspections at any time and with reasonable notice; to bring experts and consultants on site to examine or evaluate completed work or work in progress; to examine the books, ledgers, documents, papers, and records pertinent to this Contract; and to observe personnel in every phase of performance of Contract related work.
- J. Publicity.** Any publicity given to projects, programs or services provided herein, including, but not limited to, notices, information, pamphlets, press releases,

research, reports, signs, and similar public notices prepared by or for Contractor and related to the services and work to be performed under this Contract, shall identify the Office of the Attorney General, Division of Victim Services as the sponsoring agency and shall not be released without prior written approval of the Division.

- K. Suspension and Debarment.** By signing this Contract, Contractor certifies that neither it nor its principals/agents are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction or from receiving federal financial or non-financial assistance, nor are any of the participants involved in the execution of this Contract suspended, debarred, or voluntarily excluded by any federal department or agency in accordance with Executive Order 12549 (Debarment and Suspension), or 2 CFR Part 180, or are on the debarred or otherwise ineligible vendors list maintained by the federal government. Further, Contractor agrees to notify the Division by certified mail should it or of any of its agents become ineligible for payment, debarred, suspended, or voluntarily excluded from receiving federal funds during the term of this Contract.
- L. Administration of Federal Funds.** Contractor agrees its use of funds awarded herein is subject to the Uniform Administrative Requirements of 2 CFR Part 200, *et seq.*; any additional requirements set forth by the federal funding agency; all applicable regulations published in the Code of Federal Regulations; and other program guidance a provided to it by the Division.
- M. Kickbacks.** The Contractor certifies and warrants that no gratuities, kickbacks or contingency fees were paid in connection with this Contract, nor were any fees, commissions, gifts, or other considerations made contingent upon the award of this Contract. If the Contractor breaches or violates this warranty, the Division may, at its discretion, terminate this Contract without liability to the Division, or deduct from the Contract price or consideration, or otherwise recover, the full amount of any commission, percentage, brokerage, or contingency fee.
- N. Human Trafficking.** As required by 22 U.S.C. 7104(g) and 2 C.F.R. Part 175, this Contract may be terminated without penalty if a private entity that receives funds under this Contract:
- (i) Engages in severe forms of trafficking in persons during the period of time the award is in effect;
 - (ii) Procures a commercial sex act during the period of time the award is in effect; or
 - (iii) Uses forced labor in the performance of the award or subawards under the award.

- O. Environmental Policy Acts.** Contractor agrees all activities under this Contract will comply with the Clean Air Act, the Clean Water Act, the National Environmental Policy Act, and other related provisions of federal environmental protection laws, rules or regulations.
- P. Federal Audit Requirements.** Contractor agrees that if it expends an aggregate amount in excess of the amount set forth in 2 CFR Part 200, Subpart F in federal awards during its fiscal year, it must undergo an organization-wide financial and compliance single audit. Contractor agrees to comply with the audit requirements of the U.S. General Accounting Office Government Auditing Standards and Audit Requirements of 2 CFR Part 200, Subpart F. and shall submit verification of its compliance to the Division using Attachment A, Subgrantee Audit Requirements, which is attached to and incorporated into this Contract by this reference. If findings are made which cover any part of this Contract, Contractor shall provide one (1) copy of the audit report to the Division and require the release of the audit report by its auditor be held until adjusting entries are disclosed and made to Division's records.
- Q. Non-Supplanting Certification.** Contractor hereby affirms that federal grant funds shall be used to supplement existing funds, and shall not replace (supplant) funds that have been appropriated for the same purpose. Contractor should be able to document that any reduction in non-federal resources occurred for reasons other than the receipt or expected receipt of federal funds under this Contract.
- R. Program Income.** Contractor shall not deposit grant funds in an interest bearing account without prior approval of the Division. Any income attributable to the grant funds distributed under this Contract must be used to increase the scope of the program or returned to the Division.
- S. Indirect Cost.** Certain Wyoming Office of the Attorney General, Division of Victim Services recipients have the option of electing to use the "de minimis" indirect cost rate. An applicant that is eligible to use the "de minimis" rate and that wishes to use the "de minimis" rate should attach written documentation to the application that advises the Division of both (1) the applicant's eligibility to use the "de minimis" rate, and (2) its election to do so. If an eligible applicant elects the "de minimis" rate, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. The "de minimis" rate may no longer be used once an approved federally negotiated indirect cost rate is in place. (No entity that ever has had a federally approved negotiated indirect cost rate is eligible to use the "de minimis" rate.) For the "de minimis" rate requirements (including on eligibility to elect to use the rate), see 2 C.F.R. 200.414(f).
- T. Assumption of Risk.** The Contractor shall be responsible for any loss of state or federal funding, either administrative or program dollars, due to the Contractor's

failure to comply with state or federal requirements. The Division shall notify the Contractor of any state or federal determination of noncompliance.

- U. **Copyright License and Patent Rights.** Contractor acknowledges that federal grantor, the State of Wyoming, and the Division reserve a royalty-free, nonexclusive, unlimited, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to use, for federal and state government purposes: (1) the copyright in any work developed under this Contract; and (2) any rights of copyright to which Contractor purchases ownership using funds awarded under this Contract. Contractor must consult with the Division regarding any patent rights that arise from, or are purchased with, funds awarded under this Contract.
- V. **Applicability of Appendix II to 2 CFR Part 200.** This Contract has been funded, in whole or in part, with an Award of Federal funds and is bound by the federal contract provisions required by the Uniform Guidance Appendix II of 2 CFR Part 200 (the Federal Contract Provisions), incorporated herein by this reference. In the event of a conflict between the Special Provisions section of this Contract, or any attachments or exhibits incorporated herein, and the Federal Contract Provisions, the Federal Contract Provisions shall control. Failure to comply with the Federal Contract Provisions shall constitute an event of default under this Contract. If such a default remains uncured five (5) calendar days following the termination of a thirty (30) day prior written notice period, the Division may terminate this Contract. This remedy will be in addition to any other remedy available to the State of Wyoming and the Division under this Contract, at law, or in equity.

8. General Provisions.

- A. **Amendments.** Any changes, modifications, revisions or amendments to this Contract which are mutually agreed upon by the parties to this Contract shall be incorporated by written instrument, executed by all parties to this Contract.
- B. **Applicable Law, Rules of Construction, and Venue.** The construction, interpretation, and enforcement of this Contract shall be governed by the laws of the State of Wyoming, without regard to conflicts of law principles. The terms "hereof," "hereunder," "herein," and words of similar import, are intended to refer to this Contract as a whole and not to any particular provision or part. The Courts of the State of Wyoming shall have jurisdiction over this Contract and the parties. The venue shall be the First Judicial District, Laramie County, Wyoming.
- C. **Assignment Prohibited and Contract Shall Not be Used as Collateral.** Neither party shall assign or otherwise transfer any of the rights or delegate any of the duties set out in this Contract without the prior written consent of the other party. The Contractor shall not use this Contract, or any portion thereof, for collateral for any financial obligation without the prior written permission of the Division.

- D. Audit and Access to Records.** The Division and its representatives shall have access to any books, documents, papers, electronic data, and records of the Contractor, which are pertinent to this Contract. The Division may request a standard audit of a Contractor's financial records to be completed at the Contractor's expense. The Contractor shall maintain such records for seven (7) years after termination of the Contract, or for one (1) year after the final resolution of any dispute arising from the Contract, whichever is later.
- E. Availability of Funds.** Each payment obligation of the Division is conditioned upon the availability of government funds which are appropriated or allocated for the payment of this obligation and which may be limited for any reason including, but not limited to, congressional, legislative, gubernatorial, or administrative action. If funds are not allocated and available for continued performance of the Contract, the Contract may be terminated by the Division at the end of the period for which the funds are available. The Division shall notify the Contractor at the earliest possible time of the services which will or may be affected by a shortage of funds. No penalty shall accrue to the Division in the event this provision is exercised, and the Division shall not be obligated or liable for any future payments due or for any damages as a result of termination under this section.
- F. Award of Related Contracts.** The Division, under the applicable Rules and Regulations of the Division of Victim Services, may award supplemental or successor contracts for work related to this Contract or may award contracts to other contractors for work related to this Contract. The Contractor shall cooperate fully with other contractors and the Division in all such cases.
- G. Certificate of Good Standing.** Contractor shall provide to the Division a Certificate of Good Standing from the Wyoming Secretary of State, or other proof that Contractor is authorized to conduct business in the State of Wyoming, if required, before performing work under this Contract. Contractor shall ensure that annual filings and corporate taxes due and owing to the Secretary of State's office are up-to-date before signing this Contract.
- H. Compliance with Laws.** The Contractor shall keep informed of and comply with all applicable federal and state laws and federal and state rules and regulations in the performance of this Contract, specifically including: Wyo. Stat. § 1-40-118(b), Wyoming Nonprofit Corporations Act, Wyo. Stats. §§ 17-19-101 through 17-19-1807, the applicable Rules and Regulations of the Division of Victim Services, and all subsequent amendments which relate to this Contract and the services to be provided.
- I. Entirety of Contract.** This Contract, consisting of twelve (12) pages; Attachment A, Subgrantee Audit Requirements, consisting of one (1) page; Attachment B,

Certified Assurances & Special Conditions, consisting of twelve (12) pages; the grant proposals, which are on file with the Division; and the Federal Contract Provisions, represent the entire and integrated Contract between the parties and supersede all prior negotiations, representations and agreements, whether written or oral. In the event of a conflict between the language of this Contract and the language of any attachments or documents incorporated by reference, the language of this Contract shall control.

- J. **Ethics.** Contractor shall keep informed of and comply with the Wyoming Ethics and Disclosure Act (Wyo. Stat. § 9-13-101, *et seq.*), and any and all ethical standards governing Contractor's profession.
- K. **Force Majeure.** Neither party shall be liable for failure to perform under this Contract if such failure to perform arises out of causes beyond the control and without the fault or negligence of the nonperforming party. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, epidemics, quarantine restrictions, freight embargoes, and unusually severe weather. This provision shall become effective only if the party failing to perform immediately notifies the other party of the extent and nature of the problem, limits delay in performance to that required by the event, and takes all reasonable steps to minimize delays.
- L. **Indemnification.** Each party to this Contract shall assume the risk of any liability arising from its own conduct. Neither party agrees to insure, defend, or indemnify the other.
- M. **Independent Contractor.** The Contractor shall function as an independent contractor for the purposes of this Contract, and shall not be considered an employee of the State of Wyoming for any purpose. Consistent with the express terms of this Contract, the Contractor shall be free from control or direction over the details of the performance of services under this Contract. The Contractor shall assume sole responsibility for any debts or liabilities that may be incurred by the Contractor in fulfilling the terms of this Contract, and shall be solely responsible for the payment of all federal, state, and local taxes which may accrue because of this Contract. Nothing in this Contract shall be interpreted as authorizing the Contractor or its agents or employees to act as an agent or representative for or on behalf of the State of Wyoming or the Division, or to incur any obligation of any kind on behalf of the State of Wyoming or the Division. The Contractor agrees that no health or hospitalization benefits, workers' compensation, unemployment insurance, or similar benefits available to State of Wyoming employees will inure to the benefit of the Contractor or the Contractor's agents or employees as a result of this Contract.
- N. **Notices.** All notices arising out of, or from, the provisions of this Contract shall be

in writing, either by regular mail or delivery in person at the addresses provided under this Contract.

- O. Prior Approval.** This Contract shall not be binding upon either party, no services shall be performed, and the Wyoming State Auditor shall not draw warrants for payment, until this Contract has been fully executed, approved as to form by the Office of the Attorney General, filed with and approved by A&I Procurement, and approved by the Governor of the State of Wyoming, or his designee, if required by Wyo. Stat. § 9-2-3204(b)(iv).
- P. Ownership and Return of Documents and Information.** The Division is the official custodian and owns all documents, data compilations, reports, computer programs, photographs, data, and other work provided to or produced by the Contractor in the performance of this Contract. Upon termination of services, for any reason, Contractor agrees to return all such original and derivative information and documents to the Division in a useable format. In the case of electronic transmission, such transmission shall be secured. The return of information by any other means shall be by a parcel service that utilizes tracking numbers.
- Q. Severability.** Should any portion of this Contract be judicially determined to be illegal or unenforceable, the remainder of the Contract shall continue in full force and effect, and the parties may renegotiate the terms affected by the severance.
- R. Sovereign Immunity and Limitations.** Pursuant to Wyo. Stat. § 1-39-104(a), the State of Wyoming and the Division expressly reserve sovereign immunity by entering into this Contract and the Contractor expressly reserves governmental immunity. Each of them specifically retains all immunities and defenses available to them as sovereigns or governmental entities pursuant to Wyo. Stat. § 1-39-101, *et seq.*, and all other applicable law. The parties acknowledge that the State of Wyoming has sovereign immunity and only the Wyoming Legislature has the power to waive sovereign immunity. Designations of venue, choice of law, enforcement actions, and similar provisions shall not be construed as a waiver of sovereign immunity. The parties agree that any ambiguity in this Contract shall not be strictly construed, either against or for either party, except that any ambiguity as to immunity shall be construed in favor of immunity.
- S. Termination of Contract.** This Contract may be terminated, without cause, by either party upon thirty (30) days written notice of termination to the other party. This Contract may be terminated by the Division immediately for cause if the Contractor fails to perform in accordance with the terms of this Contract.
 - (i)** The Contractor agrees to termination of the Contract in accordance with the applicable Rules and Regulations of the Division of Victim Services after the occurrence of any of the following events unless the deficiency is

corrected to the satisfaction of the Division:

- (ii) The Contractor is not using Contract funds for Contract purposes;
- (iii) The Contract program is not providing services to victims of crime consistent with Wyo. Stat. § 1-40-118(b);
- (iv) The program is not of an acceptable standard or quality under the applicable Rules and Regulations of the Division of Victim Services;
- (v) The Contractor commits an act or omission in violation of federal, state, or local laws or Rules and Regulations of the Division of Victim Services which would affect services to clients served under this Contract.

- T. Third-Party Beneficiary Rights.** The parties do not intend to create in any other individual or entity the status of third-party beneficiary, and this Contract shall not be construed so as to create such status. The rights, duties, and obligations contained in this Contract shall operate only between the parties to this Contract, and shall inure solely to the benefit of the parties to this Contract. The provisions of this Contract are intended only to assist the parties in determining and performing their obligations under this Contract.
- U. Time is of the Essence.** Time is of the essence in all provisions of this Contract.
- V. Titles Not Controlling.** Titles of sections and subsections are for reference only and shall not be used to construe the language in this Contract.
- W. Waiver.** The waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. Failure to object to a breach shall not constitute a waiver.
- X. Counterparts.** This Contract may be executed in counterparts. Each counterpart, when executed and delivered, shall be deemed an original and all counterparts together shall constitute one and the same Contract. Delivery by the Contractor of an originally signed counterpart of this Contract by facsimile or PDF shall be followed up immediately by delivery of the originally signed counterpart to the Division.

THE REMAINDER OF THIS PAGE WAS INTENTIONALLY LEFT BLANK.

9. **Signatures.** The parties to this Contract, either personally or through their duly authorized representatives, have executed this Contract on the dates set out below, and certify that they have read, understood, and agreed to the terms and conditions of this Contract.

The Effective Date of this Contract is the date of the signature last affixed to this page.

DIVISION:

State of Wyoming, Office of the Attorney General, Division of Victim Services

Cara Boyle Chambers, Director

Date

CONTRACTOR:

Sweetwater County Attorney's Office



Daniel Erramouspe, County Attorney
Sweetwater County Attorney's Office

7/9/26

Date

ATTORNEY GENERAL'S OFFICE: APPROVAL AS TO FORM

 # 257202

Tyler M. Renner, Supervising Attorney General

06-18-2026

Date

9. **Signatures.** The parties to this Contract, either personally or through their duly authorized representatives, have executed this Contract on the dates set out below, and certify that they have read, understood, and agreed to the terms and conditions of this Contract.

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State of Wyoming, Office of the Attorney General, Division of Victim Services

Cara Boyle Chambers, Director

Date

CONTRACTOR:

Sweetwater County Attorney's Office



Daniel Erramouspe, County Attorney
Sweetwater County Attorney's Office

7/9/26
Date

ATTORNEY GENERAL'S OFFICE: APPROVAL AS TO FORM

 #257202
Tyler M. Renner, Supervising Attorney General

06-18-2026
Date

ATTACHMENT A
Wyoming Office of the Attorney General
Division of Victim Services

Subgrantee Audit Requirements per
2 CFR Part 200 Subpart F

2 CFR 200 Subpart F – Audit Requirements, requires the Wyoming Attorney General’s Office Division of Victim Services to monitor our subgrantees of federal awards to determine whether they have met the audit requirements of the circular and whether they are in compliance with federal laws and regulations.

Accordingly, we request that you check one of the following options and fill in required information for the entity that corresponds to the SAM.gov registration (Unique Entity ID) submitted to the Division.

1. We have completed our 2 CFR 200 Subpart F audit requirements for the fiscal year **ended** _____.

_____.
A copy of the audit report is enclosed.

(If audit findings were noted, enclose a copy of the responses, identify if the response was within 6 months of the findings, explain what management decisions were made to correct the findings.)

2. ✓ We expect our 2 CFR 200 Subpart F audit for the fiscal year **ended** 6/30/26 to be completed by 12/31/26. A copy of our audit report will be forwarded to the Wyoming Office of the Attorney General Division of Victim Services within 30 days of receipt of the report.

3. We are not subject to 2 CFR 200 Subpart F audit requirements because:

_____ We **expended** less than \$1,000,000 in federal awards annually.
Total federal awards **expended** for the fiscal year **ended** _____ was in the amount of \$ _____ **(Include total of all federal grants)**

_____ Other (please explain) _____

Sweetwater County

Subgrantee Name

Daniel Erramonspe

Print Name

[Signature]

Signature

County Attorney

Title

7/9/24

Date

Please provide all appropriate documentation regarding your organization’s compliance with audit requirements, sign and date this letter and return it to your Regional Program Manager at the Wyoming Office of the Attorney General Division of Victim Services, 320 West 25th Street 2nd Floor, Cheyenne, WY 82002.

ATTACHMENT B

CERTIFIED ASSURANCES & SPECIAL CONDITIONS

DOJ Grants (VOCA, VAWA, SASP):

- **Applicability of Part 200 Uniform Requirements and DOJ Grants Financial Guide**

The Contractor agrees to comply with the applicable audit requirements of 2 CFR Part 200 or OMB Circular A-133, and further understands and agrees that funds may be withheld, or other related requirements may be imposed, if outstanding audit issues (if any) are not satisfactorily and promptly addressed as further described in the audit requirements and the current addition of the DOJ Grants Financial Guide. The Contractor also agrees that all financial records pertinent to this award, including the general accounting ledger and all supporting documents, are subject to agency review through the life of the award, during the close-out process, and for three years after closure of the award or as long as the records are retained, whichever is longer, pursuant to 2 CFR 200.334, 200.337.

- **Compliance with DOJ Grants Financial Guide**

The Contractor agrees to comply with the current edition of the Department of Justice Grants Financial Guide as posted on the OJP website at <https://ojp.gov/financialguide/DOJ/Index.htm>, including any updated version that may be posted during the period of performance.

- **Requirements related to System for Award Management and Unique Entity Identifiers**

The Contractor must comply with the applicable requirements regarding the System for Award Management (SAM), currently accessible at <http://www.sam.gov>. This includes applicable requirements regarding registration with SAM, as well as maintaining the currency of information in SAM.

The Contractor also must comply with applicable restrictions on subawards ("subgrants") to first-tier sub-contractors (first-tier "subcontractors"), including restrictions on subawards to entities that do not acquire and provide (to the Division) the unique entity identifier assigned by SAM.

The details of the Contractor's obligations related to SAM and to unique entity identifiers are posted on the OJP website at <http://ojp.gov/funding/Explore/SAM.htm> (Award condition: System for Award Management (SAM) and Universal Identifier Requirements), and are incorporated by reference here.

This special condition does not apply to an award to an individual who received the award as a natural person (i.e., unrelated to any business or non-profit organization that he or she may own or operate in his or her name).

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

- **Employment eligibility verification for hiring under the award**

1. The Contractor must-

- a. Ensure that, as part of the hiring process for any position within the United States that is or will be funded (in whole or in part) with award funds, the Contractor properly verifies the employment eligibility of the individual who is being hired, consistent with the provisions of 8 U.S.C. 1324a(a)(1).
- b. Notify all persons associated with the Contractor who are or will be involved in activities under this award of both –
 - i. This award requirement for verification of employment eligibility, and
 - ii. The associated provisions in 8 U.S.C. 1324a(a)(1). that, generally speaking, make it unlawful, in the United States, to hire (or recruit for employment) certain aliens.
- c. Provide training (to the extent necessary) to those persons required by this condition to be notified of the award requirement for employment eligibility verification and of the associated provisions of 8 U.S.C. 1324a(a)(1).
- d. As part of the record keeping for the award (including pursuant to the Part 200 Uniform Requirements), maintain records of all employment eligibility verifications pertinent to compliance with this award condition in accordance with Form I-9 record retention requirements, as well as records of all pertinent notifications and trainings.

2. Allowable costs

To the extent that such costs are not reimbursed under any other federal program, award funds may be obligated for the reasonable, necessary, and allocable costs (if any) of actions designed to ensure compliance with this condition.

3. Rules of construction

- a. Staff involved in the hiring process

For purposes of this condition, persons “who are or will be involved in activities under this award” specifically includes (without limitation) any and all Contractor officials or other staff who are or will be involved in the hiring process with respect to a position that is or will be funded (in whole or in part) with award funds.

- b. Employment eligibility confirmation with E-Verify

For purposes of satisfying the requirements of this condition regarding verification of employment eligibility, the recipient (or any subrecipient) may choose to participate in, and use, E-Verify (www.e-verify.gov), provided an appropriate person authorized to act on behalf of the contractor uses E-Verify (and follows the proper E-Verify procedures, including in the event of a “Tentative Nonconfirmation” or a “Final Nonconfirmation”) to confirm employment eligibility for each hiring for a position in the United States that is or will be funded (in whole or in part) with award funds.

Attachment B

To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

- c. "United States" specifically includes the District of Columbia, Puerto Rico, Guam, the Virgin Islands of the United States, and the Commonwealth of the Northern Mariana Islands.
 - d. Nothing in this condition shall be understood to authorize or require any contractor, any person or other entity, to violate any federal law, including any applicable civil rights or nondiscrimination law.
 - e. Nothing in this condition, including in paragraph 3b, shall be understood to relieve any contractor, or any person, or other entity, of any obligation otherwise imposed by law, including 8 U.S.C. 1324a(a)(1).
- Questions about E-Verify should be directed to DHS. For more information about E-Verify visit the E-Verify website (<https://www.everify.gov/>) or email E-Verify at E-Verify@dhs.gov. E-Verify employer agents can email E-Verify at E-VerifyEmployerAgent@dhs.gov.

- **Requirement to report actual or imminent breach of personally identifiable information**

The Contractor must have written procedures in place to respond in the event of an actual or imminent breach (as defined in OMB M-17-12) if it 1) creates, collects, uses, processes, stores, maintains, disseminates, discloses, or disposes of personally identifiable information (PII) (as defined in 2 C.F.R. 200.1) within the scope of a DOJ grant funded program or activity, or 2) uses or operates a Federal information system (as defined in OMB Circular A-130). The Contractor's breach procedures must include a requirement to report actual or imminent breach of PII to a Division of Victim Services Program Manager no later than twelve (12) hours after an occurrence of an actual breach, or the detection of an imminent breach.

- **Specific post-award approval required to use a noncompetitive approach in a procurement contract.**

The Contractor must comply with all applicable requirements to obtain specific advance approval to use a noncompetitive approach in any procurement contract that would exceed the Simplified Acquisition Threshold (currently \$250,000). This condition applies to agreements that – for purposes of federal grants administrative requirements – OJP considers a procurement "contract" (and therefore does not consider a subaward).

The details of the requirement for advance approval to use a noncompetitive approach in a procurement contract under an OJP award are posted on the OJP web site at <https://ojp.gov/funding/Explore/noncompetitiveProcurement.htm>.

Requirements pertaining to prohibited conduct related to trafficking in persons

The Contractor must comply with all applicable requirements (including requirements to report allegations) pertaining to prohibited conduct related to the trafficking of persons,

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

whether on the part of the Contractor, or individuals defined (for purposes of this condition) as “employees” of the Contractor.

The details of the Contractor’s obligations related to prohibited conduct related to trafficking in persons are posed on the OJP and OVW websites, and are incorporated by reference here.

OJP: <https://ojp.gov/funding/Explore/ProhibitedConduct-Trafficking/htm> (Award condition: Prohibited conduct by recipients and subrecipients related to trafficking in persons (including reporting requirements and OJP authority to terminate award).

OVW: <https://www.justice.gov/ovw/award-conditions> (Award Condition: Prohibited conduct by recipients and subrecipients related to trafficking in persons (including reporting requirements and OVW authority to terminate award).

- **Determination of suitability to interact with participating minors**

The Contractor must make determinations of suitability before certain individuals may interact with participating minors. This requirement applies regardless of an individual’s employment status. The details of this requirement are posted on the OJP and OVW websites (Award condition: Determination of suitability required, in advance, for certain individuals who may interact with participating minors), and are incorporated by reference here. OJP: <https://ojp.gov/funding/Explore/Interact-Minors.htm>

OVW: <https://www.justice.gov/ovw/award-conditions>

- **Training Guiding Principles**

The Contractor understands and agrees that any training or training materials developed or delivered with funding provided under this award must adhere to the OJP and/or OVW Training Guiding Principles for Grantees and Subgrantees, available at:

OJP: <https://ojp.gov/funding/Implement/TrainingPrinciplesForGrantees-Subgrantees.htm>

OVW: <https://www.justice.gov/ovw/grantees#Resources>

- **Compliance with applicable rules regarding approval, planning, and reporting of conferences, meetings, trainings, and other events**

The Contractor must comply with all applicable laws, regulations, policies, and official DOJ guidance (including specific cost limits, prior approval and reporting requirements, where applicable) governing the use of federal funds for expenses related to conferences (as that term is defined by DOJ), including the provision of food and/or beverages at such conference, and costs of attendance at such conferences.

Information on the pertinent DOJ definition of conferences and the rules applicable to this award appears in the DOJ Grants Financial Guide (currently, as section 3.10 of “Postaward Requirements” in the “DOJ Grants Financial Guide”).

- **Compliance with applicable nondiscrimination provisions.**

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney’s Office

The Victims of Crime Act, as amended, 34 U.S.C. § 20110(e)), and the Department of Justice implementing regulation at 81 Fed. Reg. 44,515, 44,532 (July 8, 2016) (to be codified at 28 C.F.R. § 94.114), prohibits OVC grantees from discriminating against any person on the basis of race, color, national origin, sex, religion, and disability in the delivery of services and employment practices. The Contractor acknowledges that it will comply with this provision.

The Contractor will comply with any applicable nondiscrimination provisions, which may include the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. § 10228(c)); the Victims of Crime Act (42 U.S.C. § 10604(e)); the Juvenile Justice and Delinquency Prevention Act of 2002 (34 U.S.C. § 11182(b)); the Violence Against Women Act (34 U.S.C. § 12291(b)(13)); the Civil Rights Act of 1964 (42 U.S.C. § 2000d); the Indian Civil Rights Act (25 U.S.C. §§ 1301-1303); the Rehabilitation Act of 1973 (29 U.S.C. § 794); the Americans with Disabilities Act of 1990 (42 U.S.C. §§ 12131- 34); the Education Amendments of 1972 (20 U.S.C. §§ 1681, 1683, 1685-86); and the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-07). It will also comply with Ex. Order 13279, Equal Protection of the Laws for Faith Based and Community Organizations; Executive Order 13559, Fundamental Principles and Policymaking Criteria for Partnerships with Faith-Based and Other Neighborhood Organizations.

The Contractor also understands that (in addition to any applicable program-specific regulations and to applicable federal regulations that pertain to civil rights and nondiscrimination) the federal regulations applicable to the award (if any) made by the Department based on the application may include, but are not limited to, 2 C.F.R. Part 2800 (the DOJ "Part 200 Uniform Requirements") and 28 C.F.R. Parts 22 (confidentiality - research and statistical information), 23 (criminal intelligence systems), 38 (regarding faith-based or religious organizations participating in federal financial assistance programs), and 46 (human subjects protection).

- **Compliance with Federal civil rights and nondiscrimination laws**

The Contractor certifies that it does not operate any programs (including any such programs having components relating to diversity, equity, and inclusion) that violate any applicable Federal civil rights or nondiscrimination laws.

- **Compliance with DOJ regulations pertaining to civil rights and nondiscrimination – 28 C.F.R. Part 38**

The Contractor must comply with all applicable requirements of 28 C.F.R. Part 38.

Among other things, 28 C.F.R. Part 38 states that a faith-based organization retains its independence from the government and may continue to carry out its mission consistent with religious freedom and conscience protections in federal law. Part 38 further states that an organization may not use direct federal financial assistance from the Department of Justice to support or engage in explicitly religious activities except when consistent with the Establishment Clause of the First Amendment and any other applicable requirements.

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

An organization receiving federal financial assistance also may not, in providing services funded by the Department of Justice, or in their outreach activities related to such services, discriminate against a program beneficiary on the basis of religion, a religious belief, a refusal to hold a religious belief, or refusal to attend or participate in a religious practice. includes rules that prohibit specific forms of discrimination on the basis of religion, a religious belief, a refusal to hold a religious belief, or refusal to attend or participate in a religious practice. Part 38 also sets out rules and requirements that pertain to subrecipient organizations that engage in or conduct explicitly religious activities, as well as rules and requirements that pertain to subrecipients that are faith-based or religious organizations.

For more information on the requirements references in this condition, see <https://www.ojp.gov/program/civil-rights-office/partnerships-faith-based-and-other-neighborhood-organizations>.

- **Compliance with DOJ regulations pertaining to civil rights and nondiscrimination – 28 C.F.R. Part 42**

The Contractor must comply with all applicable requirements of 28 C.F.R. Part 42.

- **Compliance with DOJ regulations pertaining to civil rights and nondiscrimination – 28 C.F.R. Part 54**

The Contractor must comply with all applicable requirements of 28 C.F.R. Part 54, which relates to nondiscrimination on the basis of sex in certain “education programs.”

- **Compliance with Title VI of the Civil Rights Act of 1964**

The Contractor must take reasonable steps to ensure that individuals with limited English proficiency (LEP) have meaningful access to their programs and activities to comply with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of national origin, including discrimination against individuals with LEP. Such steps may require providing language assistance services, such as interpretation or translation services.

- **Restrictions on “lobbying” and policy development**

Federal funds may not be used by the Contractor, either directly or indirectly, to support or oppose enactment, repeal, modification or adoption of any law, regulation, or policy, at any level of government in order to avoid violation of 18 U.S.C. § 1913.

Another federal law generally prohibits federal funds awarded by DOJ from being used by the Contractor to pay any person to influence (or attempt to influence) a federal agency, a Member of Congress, or Congress (or an official or employee of any of them) with respect to the awarding of a federal grant or cooperative agreement, subgrant, contract, subcontract, or loan, or with respect to actions such as renewing or modifying any such

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney’s Office

award. See 31 U.S.C. § 1352. Certain exceptions to this law apply, including any exception that applies to Indian tribes and tribal organizations.

Should any question arise as to whether a particular use of Federal funds by a Contractor would or might fall within the scope of this prohibition, the Contractor is to contact the Division for guidance, and may not proceed without express prior written approval of the Division.

- **Compliance with general appropriations-law restrictions on the use of federal funds**
The Contractor, must comply with all applicable restrictions on the use of federal funds set out in federal appropriation statutes. Pertinent restrictions, for each fiscal year, are set out on the OJP and OVW websites (Award conditions: General appropriations-law restrictions on use of federal award funds), and are incorporated by reference here.

OJP: <https://ojp.gov/funding/Explore/FY19AppropriationsRestrictions.htm>

OVW: <https://www.justice.gov/ovw/award-conditions>

Should a question arise to whether a particular use of federal funds by a Contractor would or might fall within the scope of an appropriations-law restriction, the Contractor is to contact the Division or OJP for guidance, and may not proceed without the express prior written approval of the Division or OJP.

- **Reporting Potential Fraud, Waste, and Abuse, and Similar Misconduct**

The Contractor must promptly refer to the DOJ Office of the Inspector General (OIG) any credible evidence that a principal, employee, agent, sub-contractor, contractor, subcontractor, or other person has, in connection with funds under this award-- (1) submitted a claim that violates the False Claims Act; or (2) committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct.

Potential fraud, waste, abuse, or misconduct involving or relating to funds under this award should be reported to the OIG by – (1) online submission accessible via the OIG webpage at <https://oig.justice.gov/hotline/contact-grants.htm> (select “Submit Report Online”); (2) mail directed to: Office of the Inspector General, U.S. Department of Justice, Investigations Division, 950 Pennsylvania Ave., NW, Washington, DC 20530; and/or (3) by facsimile directed to the DOJ OIG Investigations Division (Attn: Grantee Reporting) at (202) 616-9881 (fax).

Additional information is available from the DOJ OIG website at <http://oig.justice.gov/hotline>.

- **Restrictions and certifications regarding non-disclosure agreements and related matters**

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

No Contractor under this award, or entity that receives a procurement contract or subcontract with any funds under this award, may require any employee or contractor to sign an internal confidentiality agreement or statement that prohibits or otherwise restricts, or purports to prohibit or restrict, the reporting (in accordance with the law) of waste, fraud, or abuse to an investigative or law enforcement representative of a federal department or agency authorized to receive such information.

The foregoing is not intended, and shall not be understood by the agency making this award, to contravene requirements applicable to Standard Form 312 (which relates to classified information), Form 4414 (which relates to sensitive compartmented information), or any other form issued by a federal department or agency governing the nondisclosure of classified information.

1) In accepting this award, the Contractor—

- a. represents that it neither is nor has required internal confidentiality agreements or statements from employees or contractors that currently prohibit or otherwise currently restrict (or purport to prohibit or restrict) employees or contractors from reporting waste, fraud, or abuse as described above; and
- b. certifies that, if it learns or is notified that it is or has been requiring its employees or contractors to execute agreements or statements that prohibit or otherwise restrict (or purport to prohibit or restrict), reporting of waste, fraud, or abuse as described above, it will immediately stop any further obligations of awards funds, will provide prompt written notification to the federal agency making this award, and will resume (or permit resumption of) such obligations only if expressly authorized to do so by that agency.

2) If the Contractor does or is authorized under this award to make subawards (“subgrants”), procurement contracts, or both—

a. it represents that—

- i) it has determined that no other entity that the Contractor’s application proposes may or will receive award funds (whether through a subaward (“subgrant”), procurement contract, or subcontract under a procurement contract) either requires or has required internal confidentiality agreements or statements from employees or contractors that currently prohibit or otherwise currently restrict (or purport to prohibit or restrict) employees or contractors from reporting waste, fraud, or abuse as described above; and

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney’s Office

- ii) it has made appropriate inquiry, or otherwise has an adequate factual basis, to support this representation, and
 - b. it certifies that, if it learns or is notified that any sub-contractor entity that receives funds under this award is or has been requiring its employees or contractors to execute agreements or statements that prohibit or otherwise restrict (or purport or restrict), reporting of waste, fraud, or abuse as described above, it will immediately stop any further obligations of award funds to or by that entity, will provide prompt written notification to the federal agency making this award, and will resume (or permit resumption of) such obligations only if expressly authorized to do so by that agency.
- **Compliance with 41 U.S.C. 4712 (including prohibitions on reprisal; notice to employees)**
 The Contractor must comply with, and is subject to, all applicable provisions of 41 U.S.C. 4712, including all applicable provisions that prohibit, under specified circumstances, discrimination against an employee as reprisal for the employee's disclosure of information related to gross mismanagement of a federal grant, a gross waste of federal funds, an abuse of authority relating to a federal grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a federal grant.

 The Contractor also must inform its employees, in writing (and in the predominant native language of the workforce), of employee rights and remedies under 41 U.S.C. 4712.

 Should a question arise as to applicability of the provisions of 41 U.S.C. 4172 to this award, the Contractor is to contact the DOJ awarding agency (OJP or OVW, as appropriate) for guidance.
- **Encouragement of policies to ban text messaging while driving**
 Pursuant to Executive Order 13513, "Federal Leadership on Reducing Text Messaging While Driving," 74 Red. Reg. 51225 (October 1, 2009), DOJ encourages Contractors and sub-Contractors ("subgrantees") to adopt and enforce policies banning employees from text messaging while driving any vehicle during the course of performing work funded by this award, and to establish workplace safety policies and conduct education, awareness, and other outreach to decrease crashes caused by distracted drivers.
- **Federal Authorization**
 The Contractor agrees to comply with all applicable requirements for authorization of any subaward. This condition applies to agreements that, for purposes of federal grants administrative requirements, OJP considers and "subaward" (and therefore does not consider a procurement "contract").
 The details of the requirement for authorization of any subaward are posted on the OJP web site at <https://ojp.gov/funding/Explore/SubawardAuthorization.htm> (Award

Attachment B
 To the Contract for Services between
 the State of Wyoming, Office of the Attorney General, Division of Victim Services
 and
 Sweetwater County Attorney's Office

condition: All subawards (“subgrants”) must have specific federal authorization, and incorporated by reference here.

VOCA-A:

- **VOCA Requirements**

The Contractor assures that it will comply with the conditions of the Victims of Crime Act (VOCA) of 1984, sections 1404(a)(2), and 1404(b)(1) and (2), 34 U.S.C. 20103(a)(2) and (b)(1) and (2) (and the applicable program guidelines and regulations), as required. Specifically, the Division certifies that funds under this award will:

- a) be awarded only to eligible victim assistance organizations, 34 U.S.C. 20103(a)(2);
- b) not to be used to supplant State and local public funds that would otherwise be available for crime victim assistance, 34 U.S.C. 20103(a)(2), or for administering the state victim assistance program, 34 U.S.C. 20110(h); and
- c) be allocated in accordance with program guidelines or regulations implementing 34 U.S.C. 20103(a)(2)(A) and 34 U.S.C. 20103(a)(2)(B) to, at a minimum, assist victims in the following categories: sexual assault, child abuse, domestic violence, and underserved victims of violent crimes as identified by the Division.

- **Requirement for data on performance and effectiveness under the award**

The Contractor must collect and maintain data that measure the performance and effectiveness of activities under this award. The data must be provided to OJP in the manner (including within timeframes) specified by OJP in the program solicitation or other applicable written guidance. Data collection supports compliance with the Government Performance and Results Act (GPRA) and GPRA Modernization Act, and other applicable laws.

- The Contractor agrees to submit a Subgrant Award Report (SAR) to OVC within ninety (90) days of awarding funds. States and territories are required to submit this information through the automated system.
- The Contractor agrees to submit quarterly performance reports on the performance metrics identified by OVC, and in the manner required by the Division and OVC. This information on the activities supported by the award funding will assist in assessing the effects that VOCA Victim Assistance funds have had on services to crime victims within the jurisdiction.
- **Specific post-award approval required to use a noncompetitive approach in a procurement contract.**

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

The Contractor must comply with all applicable requirements to obtain specific advance approval to use a noncompetitive approach in any procurement contract that would exceed the Simplified Acquisition Threshold (currently \$250,000). This condition applies to agreements that – for purposes of federal grants administrative requirements – OJP considers a procurement “contract” (and therefore does not consider a subaward).

The details of the requirement for advance approval to use a noncompetitive approach in a procurement contract under an OJP award are posted on the OJP web site at <https://ojp.gov/funding/Explore/noncompetitiveProcurement.htm>.

THE REMAINDER OF THIS PAGE WAS INTENTIONALLY LEFT BLANK.

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

Certification:

The undersigned affirms that the information contained in this document is true and accurate to the best of their knowledge.



7/9/20

Signature Chair/Board of Directors Agency Administrator/County Commissioner

Date

Daniel Erramouspe

Typed or Legibly Printed Name

80 W Flaming Gorge Way, Ste. 21

307-872-5267

Address

Green River, WY 82935

Phone

Attachment B
To the Contract for Services between
the State of Wyoming, Office of the Attorney General, Division of Victim Services
and
Sweetwater County Attorney's Office

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

Approved by OMB

0348-0046

(See reverse for public burden disclosure.)

1. Type of Federal Action: ☒ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance		2. Status of Federal Action: ☒ a. bid/offer/application ☐ b. initial award ☐ c. post-award		3. Report Type: ☒ a. initial filing ☐ b. material change For Material Change Only: year _____ quarter _____ date of last report _____	
4. Name and Address of Reporting Entity: ☐ Prime ☒ Subawardee Tier _____, if known: Congressional District, if known: WYAL			5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime: Wyoming Office of the Attorney General 123 Capitol Building Cheyenne, WY 82002 Congressional District, if known: WYAL		
6. Federal Department/Agency: Multiple - DOJ, OVC, OVW, Health & Human Services			7. Federal Program Name/Description: Multiple - VOCA, VAWA STOP, SASP, FVPSA CFDA Number, if applicable: _____		
8. Federal Action Number, if known:			9. Award Amount, if known: \$		
10. a. Name and Address of Lobbying Registrant (if individual, last name, first name, MI):			b. Individuals Performing Services (including address if different from No. 10a) (last name, first name, MI):		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.			Signature:  Print Name: <u>Daniel E. Evans</u> Title: <u>County and Prosecution Attorney</u> Telephone No.: <u>307 422-5260</u> Date: <u>7/9/20</u>		
Federal Use Only:				Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)	



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: (307) 872-3888 marchalk@sweetwatercountywy.gov; hootena@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: County Grants Manager Krisena Marchal; Assistance Public Works Director Andy Hooten	Exact Wording for Agenda: 10:25- Approval to Submit a FY 2027 CMAQ Grant Application
Preference of Placement on Agenda & Amount of Time Requested for Presentation: Morning, 5 minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information: Please see attached executive summary.	
Attachments: BOCC 7-21-26 CMAQ.pdf 1 - CMAQ Proposed Roadways.pdf 2 - CMAQ Resolution.pdf 3 - CMAQ Applicant Information.pdf 4 - CMAQ Lobbying Certificate.pdf 5 - CMAQ Title VI-EEO Provisions.pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally

Shoemaker at: shoemakers@sweetwatercountywy.gov

*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****

- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item may be rescheduled.
- In order to determine placement on the agenda, please review the county website sweetwatercountywy.gov on Thursday afternoon by clicking “Commissioner's Agenda”.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[BOCC 7-21-26 CMAQ.pdf](#)

[1 - CMAQ Proposed Roadways.pdf](#)

[2 - CMAQ Resolution.pdf](#)

[3 - CMAQ Applicant Information.pdf](#)

[4 - CMAQ Lobbying Certificate.pdf](#)

[5 - CMAQ Title VI-EEO Provisions.pdf](#)

To: Sweetwater County Board of County Commissioners
From: Krisena Marchal, Grants Manager
Date: July 21, 2026
Subject: Approval to Submit a FY 2027 CMAQ Grant Application

Executive Summary:

The Public Works Department is requesting permission to submit a FY 2027 CMAQ (Congestion Mitigation and Air Quality) grant application for \$400,000 to the Wyoming Department of Transportation. It requires a 20 percent cash match, and would need to be completed by December 31, 2029.

The purpose of CMAQ federal funding is to alleviate air-quality issues created by energy development and other industrial activity in the vicinity.

If approved, the funding will be used to apply magnesium chloride dust suppressant to various county roads.

PROPOSED FY 2027 CMAQ GRANT PROJECT			
EXPENSES	FUNDING SOURCES		TOTAL BUDGET
	CMAQ Grant	Sweetwater County Cash Match	
Dust Suppression Application 73.52 miles of magnesium chloride to nine county roads	400,000	100,000	500,000
GRANT APPLICATION	\$400,000 (80%)	\$100,000 (20%)	\$500,000 (100%)

Staff Notes:

Under this proposal, Sweetwater County is applying for the maximum allowable grant amount.

The estimated cost per mile is \$6,801.

The required cash match was included in the FY 2027 Grants Projects budget.

Attachments:

1. FY 2027 CMAQ Project – Proposed Roadways
2. Resolution 26-07-GR-01
3. CMAQ Applicant Information Form
4. Lobbying Certificate
5. Title VI/EEO Assurances/Non-Discrimination Provisions

Recommendation:

Move to approve, and authorize the Chairman to sign, Resolution 26-07-GR-01 and related documents for the submission of a Fiscal Year 2027 CMAQ grant application.

CMAQ Attachment B: Proposed Roadways & Map

****Submit one map (in the form of a digital file) showing each roadway detailing their project benefits and uses****

[illegible]

73.52

CMAQ Attachment E: Resolution
RESOLUTION NO. Resolution #26-07-GR-01

A RESOLUTION AUTHORIZING THE SUBMISSION OF AN APPLICATION FOR FEDERAL FUNDING THROUGH THE CONGESTION MITIGATION AIR QUALITY PROGRAM ADMINISTERED BY THE WYOMING DEPARTMENT OF TRANSPORTATION FOR SWEETWATER COUNTY FOR THE PURPOSES OF THE FY2027 CMAQ PROJECT.

WITNESSETH

WHEREAS, the governing body for Sweetwater County desires to participate in the Congestion Mitigation Air Quality Program (CMAQ) to assist in funding this project;

WHEREAS, the governing body for Sweetwater County recognizes the need for the project;

WHEREAS, CMAQ requires that federal funding criteria be met, and Sweetwater County agrees to ensure satisfaction of all requirements;

WHEREAS, Sweetwater County acknowledges that if funded, the CMAQ project shall be completed prior to December 31, 2029;

WHEREAS, the governing body for Sweetwater County agrees to set aside a minimum of \$100,000 as a line item in its budget for the required twenty percent (20%) local cash match on the project;

WHEREAS, the governing body for Sweetwater County acknowledges CMAQ is funded on a reimbursement basis and all invoices must be 100% paid by Sweetwater County prior to reimbursement through CMAQ (80% Federal Reimbursement). Sweetwater County acknowledges that failure to comply with this requirement may result in cancellation of the award and repayment by Sweetwater County of all funds reimbursed.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY for Sweetwater County that a funding application requesting \$400,000 in federal CMAQ funding be submitted to the Wyoming Department of Transportation – CMAQ for consideration to assist in funding for the Sweetwater County project.

BE IT FURTHER RESOLVED, THAT Andrew P. Hooten, PE is hereby designated as the Project Administrator, of Sweetwater County to act on behalf of the governing body on all matters relating to this funding application.

PASSED, APPROVED AND ADOPTED THIS 21 DAY OF JULY, 2026.

Signature
Keaton D. West. Chairman

ATTEST:

Signature
Cynthia L. Swenson, County Clerk

Congestion Mitigation and Air Quality (CMAQ) Program Applicant Information

Sponsor:

Name of Sponsor: Sweetwater County			
Sponsor Type: County Government			
SAM Unique Entity ID (UEI): WV9GN21T4C53			
Mailing Address: 80 West Flaming Gorge Way, Suite 23			
City: Green River	State: WY	Zip+4: 82935-4252	
Project Name: FY2027 Dust Suppression			
Contact Person: Andy Hooten, PE			
Title: Assistant Public Works Director			
Email: hootena@sweetwatercountywy.gov		Phone: 307.872.3922	
LPA Certified: ☒ Yes ☐ No		LPA Certification Expiration: 12/31/2028	
LPA Certified Individual (if not Contact Person): N/A			

Joint Sponsor:

Joint Sponsor: ☒ No ☐ Yes		
Joint Sponsor's Name:		
Mailing Address:		
City:	State:	Zip:
Joint Sponsor Contact Person:		
Title:		
Email:	Phone:	
LPA Certified: ☐ Yes ☐ No	LPA Certification Expiration:	
LPA Certified Individual (if not Contact Person):		

Funding Request

20% Local Match	80% Federal (CMAQ Request)	Estimated Cost Per Mile	Total Project Cost
\$100,000	\$400,000	\$6,801	\$500,000
Specify source of match funding: General Fund			

Sponsor Certification Statement

Read and check each statement below certifying:

- ☒ The Sponsor is familiar with the Congestion Mitigation Air Quality Program eligibility criteria;
- ☒ The budget accurately reflects cost of proposed project;
- ☒ The information provided is true and correct to the best of the Sponsor's knowledge;
- ☒ The Sponsor understands this is a reimbursement-based award and if funded, the Sponsor must pay costs and will be reimbursed as invoices are submitted with documentation;
- ☒ The Sponsor will be responsible for ensuring future maintenance and ongoing upkeep of the completed project.

Sponsor Signature
 (Authorized Official)
 Keaton D. West, Chairman

Date

Lobbying Certification Statement

The undersigned Keaton D. West certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for making lobbying contacts to an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form--LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions [as amended by "Government wide Guidance for New Restrictions on Lobbying," 61 Fed. Reg. 1413 (1/19/96). Note: Language in paragraph (2) herein has been modified in accordance with Section 10 of the Lobbying Disclosure Act of 1995 (P.L. 104-65, to be codified at 2 U.S.C. 1601, et seq.)]
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31, U.S.C. § 1352 (as amended by the Lobbying Disclosure Act of 1995). Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

[Note: Pursuant to 31 U.S.C. § 1352(c)(1)-(2)(A), any person who makes a prohibited expenditure or fails to file or amend a required certification or disclosure form shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such expenditure or failure.]

Sweetwater County certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Sponsor understands and agrees that the provisions of 31 U.S.C. A 3801, et seq., apply to this certification and disclosure, if any.

Signature

Keaton D. West

Printed Name, Title

Date

CMAQ Attachment F: Lobbying Certificate

IDENTIFICATION OF TITLE VI / EEO COORDINATOR

Funding Recipient/Contractor Name:	Sweetwater County +
WYDOT Project #:	FY2027 CMAQ
Project Location:	Sweetwater County
Phone #:	307.872.3921

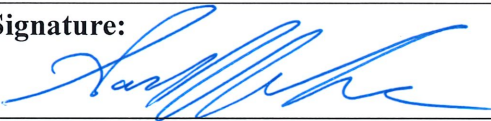
TITLE VI/EEO IDENTIFICATION REQUIREMENTS

Has the Title VI/EEO Coordinator attended the Local Public Agency training from the Wyoming Department of Transportation? <i>(Project Sponsor Only – Contractors need not respond)</i>	YES ☐	NO ☒
Has the Coordinator changed since the last submitted Identification form?	YES ☐	NO ☒
Is the Coordinator clearly identified within the organization as the individual who will process and/or notify required staff of Title VI/EEO identified issues?	YES ☒	NO ☐

TITLE VI/EEO COORDINATOR IDENTIFICATION

As required in the Equal Employment Opportunity Special Provisions included in federally funded highway construction contracts/agreements, this form acts as official identification of the Title VI/EEO Coordinator (and/or update) to the Wyoming Department of Transportation and the U.S. Federal Highway Administration (FHWA).

The aforementioned Funding Recipient/Contractor understands that additional information regarding the Coordinator, the Title VI/EEO policy and other aspects of the construction contract compliance program may be requested and/or reviewed at the request of the funding agency.

Title VI/EEO Coordinator: Garry McLean	Signature: 	Date: 6/17/24
Title VI/EEO Coordinator Work Title: Human Resources Director	Email Address: mcleang@sweetwatercountywy.gov	Phone #: 307.872.3913

APPOINTING OFFICIAL'S ACKNOWLEDGEMENT

Appointing Official's Name: Keaton D. West	Signature:
Appointing Official's Work Title: Chairman	Date:

For questions regarding this form, contact WYDOT's Office of Civil Rights Program Manager, Jeff White at 307.777.4457 or jeff.white1@wyo.gov.

The United States Department of Transportation

Standard Title VI Assurances/Non-Discrimination Provisions

DOT Order No. 1050.2A

Sweetwater County

(herein referred to as the “Recipient”), **HEREBY AGREES THAT**, as a condition to receiving any Federal financial assistance from the United States Department of Transportation (DOT), through the Federal Highway Administration (FHWA), is subject to and will comply with the following:

Statutory/Regulatory Authorities

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*, 78 stat. 252), (prohibits discrimination on the basis of race, color, national origin);
- 49 C.F.R. Part 21 (entitled *Nondiscrimination In Federally-Assisted Programs Of The Department Of Transportation—Effectuation Of Title VI Of The Civil Rights Act Of 1964*);
- 28 C.F.R. section 50.3 (U.S. Department of Justice Guidelines for Enforcement of Title VI of the Civil Rights Act of 1964);

Modal Operating Administration may include additional Statutory/Regulatory Authorities here.

The preceding statutory and regulatory cites hereinafter are referred to as the “Acts” and “Regulations,” respectively.

General Assurances

In accordance with the Acts, the Regulations, and other pertinent directives, circulars, policy, memoranda, and/or guidance, the Recipient hereby gives assurance that it will promptly take any measures necessary to ensure that:

“No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Recipient receives Federal financial assistance from DOT, including the FHWA.”

The Civil Rights Restoration Act of 1987 clarified the original intent of Congress, with respect to Title VI and other Non-discrimination requirements (The Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973) by restoring the broad, institutional-wide scope and coverage of these non-discrimination statutes and requirements to include all programs and activities of the Recipient, so long as any portion of the program is Federally-assisted.

Modal Operating Administration may include additional General Assurances in this section, or reference an addendum here.

Specific Assurances

More specifically, and without limiting the above general Assurances, the Recipient agrees with and gives the following Assurances with respect to its Federally assisted FHWA Program:

1. The Recipient agrees that each “activity,” “facility,” or “program,” as defined in §§ 21.23 (b) and 21.23 (e) of 49 C.F.R. § 21 will be (with regard to an “activity”) facilitated, or will be (with regard to a “facility”) operated, or will be (with regard to a “program”) conducted in compliance with all requirements imposed by, or pursuant to the Acts and the Regulations;
2. The Recipient will insert the following notification in all solicitations for bids, Requests For Proposals for work, or material subject to the Acts and the Regulations made in connection with all Federal Highway Programs and, in adapted form, in all proposals for negotiated agreements regardless of funding source:

“Sweetwater County, in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (78 Stat. 252, 42 U.S.C. §§ 2000d to 2000d-4) and the Regulations, hereby notifies all bidders that it will affirmatively ensure that any contract entered into pursuant to this advertisement, disadvantaged business enterprises will be afforded full opportunity to submit bids in response to this invitation and will not be discriminated against on the grounds of race, color, or national origin in consideration for an award.”;

3. The Recipient will insert the clauses of Appendix A and E of this Assurance in every contract or agreement subject to the Acts and the Regulations;
4. The Recipient will insert the clauses of Appendix B of this Assurance, as a covenant running with the land, in any deed from the United States effecting or recording a transfer of real property, structures, use, or improvements thereon or interest therein to a Recipient;
5. That where the Recipient receives Federal financial assistance to construct a facility, or part of a facility, the Assurance will extend to the entire facility and facilities operated in connection therewith;
6. That where the Recipient receives Federal financial assistance in the form, or for the acquisition of real property or an interest in real property, the Assurance will extend to rights to space on, over, or under such property;
7. That the Recipient will include the clauses set forth in Appendix C and Appendix D of this Assurance, as a covenant running with the land, in any future deeds, leases, licenses, permits, or similar instruments entered into by the Recipient with other parties:
 - a. for the subsequent transfer of real property acquired or improved under the applicable activity, project, or program; and
 - b. for the construction or use of, or access to, space on, over, or under real property acquired or improved under the applicable activity, project, or program.
8. That this Assurance obligates the Recipient for the period during which Federal financial assistance is extended to the program, except where the Federal financial assistance is to provide, or is in the form of, personal property, or real property, or interest therein, or structures or improvements thereon, in which case the Assurance obligates the Recipient, or any transferee for the longer of the following periods:
 - a. the period during which the property is used for a purpose for which the Federal financial assistance is extended, or for another purpose involving the provision of similar services or benefits; or
 - b. the period during which the Recipient retains ownership or possession of the property.

9. The Recipient will provide for such methods of administration for the program as are found by the Secretary of Transportation or the official to whom he/she delegates specific authority to give reasonable guarantee that it, other recipients, sub-recipients, sub-grantees, contractors, subcontractors, consultants, transferees, successors in interest, and other participants of Federal financial assistance under such program will comply with all requirements imposed or pursuant to the Acts, the Regulations, and this Assurance.
10. The Recipient agrees that the United States has a right to seek judicial enforcement with regard to any matter arising under the Acts, the Regulations, and this Assurance.

Modal Operating Administration may include additional Specific Assurances in this section.

By signing this ASSURANCE, _____ Sweetwater County _____ also agrees to comply (and require any sub-recipients, sub-grantees, contractors, successors, transferees, and/or assignees to comply) with all applicable provisions governing the **FHWA** access to records, accounts, documents, information, facilities, and staff. You also recognize that you must comply with any program or compliance reviews, and/or complaint investigations conducted by the **FHWA**. You must keep records, reports, and submit the material for review upon request to **FHWA**, or its designee in a timely, complete, and accurate way. Additionally, you must comply with all other reporting, data collection, and evaluation requirements, as prescribed by law or detailed in program guidance.

_____ Sweetwater County _____ gives this ASSURANCE in consideration of and for obtaining any Federal grants, loans, contracts, agreements, property, and/or discounts, or other Federal-aid and Federal financial assistance extended after the date hereof to the recipients by the Department of Transportation under the **FHWA Program**. This ASSURANCE is binding on [insert State], other recipients, sub-recipients, sub-grantees, contractors, subcontractors and their subcontractors', transferees, successors in interest, and any other participants in the **FHWA Program**. The person (s) signing below is authorized to sign this ASSURANCE on behalf of the Recipient.

_____ Sweetwater County _____

By: _____
(Signature of Authorized Official)

DATE: _____

APPENDIX A

During the performance of this contract, the contractor, for itself, its assignees, and successors in interest (hereinafter referred to as the “contractor”) agrees as follows:

1. **Compliance with Regulations:** The contractor (hereinafter includes consultants) will comply with the Acts and the Regulations relative to Nondiscrimination in Federally-assisted programs of the U.S. Department of Transportation, **Federal Highway Administration (FHWA)**, as they may be amended from time to time, which are herein incorporated by reference and made a part of this contract.
2. **Nondiscrimination:** The contractor, with regard to the work performed by it during the contract, will not discriminate on the grounds of race, color, or national origin in the selection and retention of subcontractors, including procurements of materials and leases of equipment. The contractor will not participate directly or indirectly in the discrimination prohibited by the Acts and the Regulations as set forth in Appendix E, including employment practices when the contract covers any activity, project, or program set forth in Appendix B of 49 CFR Part 21.
3. **Solicitations for Subcontracts, Including Procurements of Materials and Equipment:** In all solicitations, either by competitive bidding, or negotiation made by the contractor for work to be performed under a subcontract, including procurements of materials, or leases of equipment, each potential subcontractor or supplier will be notified by the contractor of the contractor’s obligations under this contract and the Acts and the Regulations relative to Non-discrimination on the grounds of race, color, or national origin.
4. **Information and Reports:** The contractor will provide all information and reports required by the Acts, the Regulations and directives issued pursuant thereto and will permit access to its books, records, accounts, other sources of information, and its facilities as may be determined by the Recipient or the **FHWA** to be pertinent to ascertain compliance with such Acts, Regulations, and instructions. Where any information required of a contractor is in the exclusive possession of another who fails or refuses to furnish the information, the contractor will so certify to the Recipient or the **FHWA**, as appropriate, and will set forth what efforts it has made to obtain the information.
5. **Sanctions for Noncompliance:** In the event of a contractor’s noncompliance with the Non-discrimination provisions of this contract, the Recipient will impose such contract sanctions as it or the **FHWA** may determine to be appropriate, including, but not limited to:
 - a. withholding payments to the contractor under the contract until the contractor complies; and/or
 - b. cancelling, terminating, or suspending a contract, in whole or in part.
6. **Incorporation of Provisions:** The contractor will include the provisions of paragraphs one through six in every subcontract, including procurements of materials and leases of equipment, unless exempt by the Acts, the Regulations and directives issued pursuant thereto. The contractor will take action with respect to any subcontract or procurement as the Recipient or the **FHWA** may direct as a means of enforcing such provisions including sanctions for noncompliance. Provided, that if the contractor becomes involved in, or is threatened with litigation by a subcontractor, or supplier because of such direction, the contractor may request the Recipient to enter into any litigation to protect the interests of the Recipient. In addition, the contractor may request the United States to enter into the litigation to protect the interests of the United States.

CLAUSES FOR DEEDS TRANSFERRING UNITED STATES PROPERTY

APPENDIX B

The following clauses will be included in deeds effecting or recording the transfer of real property, structures, or improvements thereon, or granting interest therein from the United States pursuant to the provisions of Assurance 4:

NOW, THEREFORE, the Department of Transportation as authorized by law and upon the condition that Sweetwater County will accept title to the lands and maintain the project constructed thereon in accordance with Moving Ahead for Progress in the 21st Century (MAP-21), the Regulations for the Administration of Federal Highway Administration (FHWA) Program, and the policies and procedures prescribed by the FHWA of the Department of Transportation in accordance and in compliance with all requirements imposed by Title 49, Code of Federal Regulations, Department of Transportation, Subtitle A, Office of the Secretary, Part 21, Non-discrimination in Federally-assisted programs of the Department of Transportation pertaining to and effectuating the provisions of Title VI of the Civil Rights Act of 1964 (78 Stat. 252; 42 U.S.C. § 2000d to 2000d-4), does hereby remise, release, quitclaim and convey unto Sweetwater County all the right, title and interest of the Department of Transportation in and to said lands described in Exhibit "A" (if applicable) attached hereto and made a part hereof.

(HABENDUM CLAUSE)

TO HAVE AND TO HOLD said lands and interests therein unto

Sweetwater County  and its successors forever, subject, however, to the covenants, conditions, restrictions and reservations herein contained as follows, which will remain in effect for the period during which the real property or structures are used for a purpose for which Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits and will be binding on Sweetwater County, its successors and assigns.

Sweetwater County, in consideration of the conveyance of said lands and interests in lands, does hereby covenant and agree as a covenant running with the land for itself, its successors and assigns, that (1) no person will on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination with regard to any facility located wholly or in part on, over, or under such lands hereby conveyed [,] [and]* (2) that Sweetwater County will use the lands and interests in lands and interests in lands so conveyed, in compliance with all requirements imposed by or pursuant to Title 49, Code of Federal Regulations, Department of Transportation, Subtitle A, Office of the Secretary, Part 21, Non-discrimination in Federally-assisted programs of the Department of Transportation, Effectuation of Title VI of the Civil Rights Act of 1964, and as said Regulations and Acts may be amended, and (3) that in the event of breach of any of the above-mentioned non-discrimination conditions, the Department will have a right to enter or re-enter said lands and facilities on said land, and that above described land and facilities will there on revert to and vest in

and become the absolute property of the Department of Transportation and its assigns as such interest existed prior to this instruction.*

(*Reverter clause and related language to be used only when it is determined that such a clause is necessary in order to effectuate the purpose of Title VI.)

CLAUSES FOR TRANSFER OF REAL PROPERTY ACQUIRED OR IMPROVED UNDER THE ACTIVITY, FACILITY OR PROGRAM

APPENDIX C

The following clauses will be included in deeds, licenses, leases, permits, or similar instruments entered into by _____ Sweetwater County _____ pursuant to the provisions of Assurance 7(a):

- A. The (grantee, lessee, permittee, etc. as appropriate) for himself/herself, his/her heirs, personal representatives, successors in interest, and assigns, as a part of the consideration hereof, does hereby covenant and agree [in the case of deeds and leases add “as a covenant running with the land”] that:
1. In the event facilities are constructed, maintained, or otherwise operated on the property described in this (deed, license, lease, permit, etc.) for a purpose for which a Department of Transportation activity, facility, or program is extended or for another purpose involving the provision of similar services or benefits, the (grantee, licensee, lessee, permittee, etc.) will maintain and operate such facilities and services in compliance with all requirements imposed by the Acts and Regulations (as may be amended) such that no person on the grounds of race, color, or national origin will be excluded from participation in, denied the benefits of, or be otherwise subjected to discrimination in the use of said facilities.
- B. With respect to licenses, leases, permits, etc., in the event of breach of any of the above Non-discrimination covenants, _____ Sweetwater County _____ will have the right to terminate the (lease, license, permit, etc.) and to enter, re-enter, and repossess said lands and facilities thereon, and hold the same as if the (lease, license, permit, etc.) had never been made or issued.*
- C. With respect to a deed, in the event of breach of any of the above Non-discrimination covenants, the _____ Sweetwater County _____ will have the right to enter or re-enter the lands and facilities thereon, and the above described lands and facilities will there upon revert to and vest in and become the absolute property of the _____ Sweetwater County _____ and its assigns.*

(*Reverter clause and related language to be used only when it is determined that such a clause is necessary to effectuate the purpose of Title VI.)

**CLAUSES FOR CONSTRUCTION/USE/ACCESS TO REAL PROPERTY ACQUIRED
UNDER THE ACTIVITY, FACILITY OR PROGRAM**

APPENDIX D

The following clauses will be included in deeds, licenses, permits, or similar instruments/agreements entered into by _____ Sweetwater County _____ pursuant to the provisions of Assurance 7(b):

- A. The (grantee, licensee, permittee, etc., as appropriate) for himself/herself, his/her heirs, personal representatives, successors in interest, and assigns, as a part of the consideration hereof, does hereby covenant and agree (in the case of deeds and leases add, "as a covenant running with the land") that (1) no person on the ground of race, color, or national origin will be excluded from participation in, denied the benefits of, or be otherwise subjected to discrimination in the use of said facilities, (2) that in the construction of any improvements on, over, or under such land, and the furnishing of services thereon, no person on the ground of race, color, or national origin will be excluded from participation in, denied the benefits of, or otherwise be subjected to discrimination, (3) that the (grantee, licensee, lessee, permittee, etc.) will use the premises in compliance with all other requirements imposed by or pursuant to the Acts and Regulations, as amended, set forth in this Assurance.
- B. With respect to (licenses, leases, permits, etc.), in the event of breach of any of the above Non-discrimination covenants, the _____ Sweetwater County _____ will have the right to terminate the (license, permit, etc., as appropriate) and to enter or re-enter and repossess said land and the facilities thereon, and hold the same as if said (license, permit, etc., as appropriate) had never been made or issued.*
- C. With respect to deeds, in the event of breach of any of the above Non-discrimination covenants, the _____ Sweetwater County _____ will there upon revert to and vest in and become the absolute property of _____ Sweetwater County _____ and its assigns.*

(*Reverter clause and related language to be used only when it is determined that such a clause is necessary to effectuate the purpose of Title VI.)

APPENDIX E

During the performance of this contract, the contractor, for itself, its assignees, and successors in interest (hereinafter referred to as the “contractor”) agrees to comply with the following non-discrimination statutes and authorities; including but not limited to:

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*, 78 stat. 252), (prohibits discrimination on the basis of race, color, national origin); and 49 CFR Part 21;
- The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, (42 U.S.C. § 4601), (prohibits unfair treatment of persons displaced or whose property has been acquired because of Federal or Federal-aid programs and projects);
- Federal-Aid Highway Act of 1973, (23 U.S.C. § 324 *et seq.*), (prohibits discrimination on the basis of sex);
- Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794 *et seq.*), as amended, (prohibits discrimination on the basis of disability); and 49 CFR Part 27;
- The Age Discrimination Act of 1975, as amended, (42 U.S.C. § 6101 *et seq.*), (prohibits discrimination on the basis of age);
- Airport and Airway Improvement Act of 1982, (49 USC § 471, Section 47123), as amended, (prohibits discrimination based on race, creed, color, national origin, or sex);
- The Civil Rights Restoration Act of 1987, (PL 100-209), (Broadened the scope, coverage and applicability of Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973, by expanding the definition of the terms “programs or activities” to include all of the programs or activities of the Federal-aid recipients, sub-recipients and contractors, whether such programs or activities are Federally funded or not);
- Titles II and III of the Americans with Disabilities Act, which prohibit discrimination on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing entities (42 U.S.C. §§ 12131 -- 12189) as implemented by Department of Transportation regulations at 49 C.F.R. parts 37 and 38;
- The Federal Aviation Administration’s Non-discrimination statute (49 U.S.C. § 47123) (prohibits discrimination on the basis of race, color, national origin, and sex);
- Executive Order 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations, which ensures non-discrimination against minority populations by discouraging programs, policies, and activities with disproportionately high and adverse human health or environmental effects on minority and low-income populations;
- Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination because of limited English proficiency (LEP). To ensure compliance with Title VI, you must take reasonable steps to ensure that LEP persons have meaningful access to your programs (70 Fed. Reg. at 74087 to 74100);
- Title IX of the Education Amendments of 1972, as amended, which prohibits you from discriminating because of sex in education programs or activities (20 U.S.C. 1681 *et seq.*).



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3921, legerskig@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: Gene Legerski, Public Works Director	Exact Wording for Agenda: 10:30- Change Order #1 for Time to the Green River Courthouse Elevator Modernization Project
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information: The original RFQ set substantial and final completion dates within the contract. Consulting with KONE, Inc, after the bid, the original dates were not realistic. Based on the contractor's schedule, the use of the Courthouse for voting, and other factors, these dates need to be changed.	
Attachments: Change Order Number 1-Time.pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov
*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****

- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item may be rescheduled.
- In order to determine placement on the agenda, please review the county website sweetwatercountywy.gov on Thursday afternoon by clicking “Commissioner's Agenda”.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[Change Order Number 1-Time.pdf](#)



Change Order:

CONTRACT INFORMATION:

Green River Courthouse
Elevator Modernization Project

CHANGE ORDER INFORMATION

Change Order Number: One (1)

Date: July 21st, 2026

OWNER: Sweetwater County, WY **CONTRACTOR:** KONE, Inc.

The contract is changed as follows:

The original RFQ set substantial and final completion dates within the contract. Consulting with KONE, Inc, after the bid, the original dates were not realistic. Based on the contractor's schedule, the use of the Courthouse for voting, and other factors, these dates need to be changed.

The original contract sum \$413,360.00

The net change by previously authorized Change Orders NA

The contract sum prior to this Change Order \$413,360.00

The contract sum will be (~~increased~~) (~~decreased~~) (unchanged)
By this Change Order in the amount of \$0.00

The new contract sum, including this Change Order, will be \$413,360.00

The Contract Time will be changed from substantial completion on June 27th, 2026, to **March 26th, 2027**, and the final completion date from July 25th, 2026, to **April 28th, 2027**.

Contractor:

Owner:

Signature

Signature

Megann Long-Senior Project
Manager-Modernization

Keaton D. West-Chairman

Date

Date

Attest: Devin Betz-Modernization
Superintendent

Attest: Cynthia L. Swenson-County Clerk



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3921 legerskig@sweetwatercountywy.gov and 307-872-3830 deleonj@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: Gene Legerski, Sweetwater County Public Works Director and John DeLeon, Sweetwater County Chief Deputy County Attorney	Exact Wording for Agenda: 10:35- Real Property Lease No. 8-09831 Between Sweetwater County and State of Wyoming, Department of Administration and Information, General Services Division
Preference of Placement on Agenda & Amount of Time Requested for Presentation: No preference on placement, 5 minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: WIC LEASE USING WGCA FOR INSURANCE .pdf	

INSTRUCTIONS:

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80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[WIC LEASE USING WGCA FOR INSURANCE .pdf](#)

**REAL PROPERTY LEASE NO. 8-09831 BETWEEN
SWEETWATER COUNTY
AND
STATE OF WYOMING, DEPARTMENT OF ADMINISTRATION & INFORMATION,
GENERAL SERVICES DIVISION**

1. **Parties.** This Lease is entered into by and between Sweetwater County (Lessor), whose address is: 80 West Flaming Gorge Way, Green River, Wyoming 82935 and the State of Wyoming, Department of Administration & Information, General Services Division, (Lessee) whose address is: 2323 Carey Avenue, Cheyenne, Wyoming 82002.

2. **Purpose of Lease.**

A. Lessor is the sole owner of the property described below, and desires to lease a designated portion of the property to Lessee for government business purposes. For consideration, Lessor hereby leases to Lessee a designated portion of its property, located in the County of Sweetwater, State of Wyoming, and more particularly described as follows:

Approximately nine hundred ninety (990) square feet of office space and approximately one hundred (100) square feet of storage space located on the second floor of the Sweetwater County HHS Building at 333 Broadway Street, Rock Springs, Wyoming 82901 (the "Premises").

B. Lessee is the leasing agent for the State of Wyoming, and desires to lease the Premises for occupancy by the Department of Health, Women, Infants & Children (WIC).

C. The parties desire to enter into this Lease defining their rights, duties, and liabilities relating to the lease of the Premises. The Effective Date of this Lease shall be the date of the last signature.

D. Lessor covenants and warrants that no encumbrances exist on the Premises which could affect Lessee's use of the Premises.

3. **Term of Lease.**

A. Lessor leases the above Premises for a term commencing July 1, 2026 (Commencement Date) or on the Effective Date, whichever is later and terminating June 30, 2028, or sooner as provided herein (Termination Date). This Lease is not valid and shall not become effective until it is signed by an authorized representative of the Lessor and an authorized representative of the Lessee, has been approved and signed by an authorized representative of the Department of Administration and Information, approved as to form by the Office of the Wyoming Attorney General, approved by the Governor or his designee if required by Wyo. Stat. § 9-2-3204(b)(iv)(D), and approved by the Administrator if required by Wyo. Stat. § 9-2-3204(b)(xix)(A). This Lease may be extended under the same terms and conditions by mutual written agreement of the parties to this Lease.

- B. If Lessee, upon mutual agreement with the Lessor, occupies the Premises prior to the Commencement Date, rent will commence at the time of such early occupancy and shall be prorated based on the number of days in the month of early occupancy, subject to the availability of government funds. The Termination Date shall remain the same.
- C. If, for any reason, Lessor cannot deliver possession of the Premises to the Lessee by the Commencement Date, Lessee shall not, except as otherwise provided herein, be obligated to pay rent or perform any other obligation of Lessee under the terms of this Lease until Lessor delivers possession of the Premises to the Lessee. In the event of such delayed possession, the term of the Lease shall commence on the date the Lessee takes possession of the Premises and rent shall be reduced on a per diem basis.

4. **Rent Payment.**

The rent to be paid by Lessee to Lessor shall be as follows:

Payments will be issued within twenty (20) days of the period start date shown in the Payment Schedule below. No payment shall be made under this Lease for any tenancy occurring prior to the date upon which the last required signature is affixed to this Lease.

Table 1: Payment Schedule

Payment Installment	Period	Amount (written)	Amount
1	July 1, 2026 to June 30, 2027	Nineteen thousand, eight hundred dollars and 00/100	\$19,800.00
2	July 1, 2027 to June 30, 2028	Nineteen thousand, eight hundred dollars and 00/100	\$19,800.00
N/A	TOTAL NOT TO EXCEED	Thirty-nine thousand, six hundred dollars and 00/100	\$39,600.00

5. **Responsibilities of Lessor.**

- A. **Parking.** Lessor shall provide parking spaces for use by the Lessee, and the occupant agency's employees and customers, on a first come first served basis.
- B. **Quiet Enjoyment.** Lessor warrants that Lessee shall be granted peaceable and quiet enjoyment of the Premises free from any eviction or interference by Lessor if Lessee pays the rent, and otherwise performs the terms and conditions imposed on Lessee.
- C. **Taxes.** Lessor shall pay all real property taxes, assessments, or other governmental charges that may become due in connection with this Lease or that may be imposed upon the Premises in connection with the operation and maintenance of the Premises.

- D. Customary Maintenance.** Lessor, at its expense, shall provide the following customary maintenance services and supplies that are required to keep the building, interior offices, breakrooms, furniture, and fixtures in a neat, clean, and sanitary condition.
- (i) Nightly janitorial services on each business day shall include, emptying all trash cans and replacing liners as needed; removing trash from building to proper bins; vacuuming high traffic areas; cleaning entrance door mats; cleaning bathrooms; cleaning and servicing all drinking fountains, breakroom, and bathroom sink areas; and filling and servicing soap, paper towel, and toilet paper dispensers.
 - (ii) Weekly janitorial services shall include cleaning all door and partition glass; spot cleaning carpets where needed; damp mopping hard surface floor areas; dusting all horizontal surfaces with the exception of desktops; disinfecting doorknobs, switch plates, and latch fixtures with germicidal cleaner; and vacuuming all carpets thoroughly.
 - (iii) Lessor shall provide all cleaning supplies and equipment, including but not limited to soap, waxes, disinfectants, trash can liners, mops, and vacuums. Lessor shall provide all expendable restroom supplies, including but not limited to toilet paper, paper towels, and hand soap.
 - (iv) Lessor shall repair or replace carpet that is worn or becomes hazardous, and have the carpet cleaned every three (3) years.
 - (v) Lessor shall provide any needed lawn or landscaping care, interior pest control, and exterior pest control in a timely manner.
 - (vi) Prior to the start of each business day, Lessor shall be responsible for snow and ice removal from building entrances, exits, sidewalks, driveways, and parking areas. If conditions warrant, Lessor is responsible for additional snow and ice removal during the business day based on weather conditions and the accumulation of snow, sleet, and ice. Lessor shall correct all unsafe conditions relating to freezing and thawing in a timely manner.
- E. Utilities.** All applications and connections for necessary utility services on the Premises, with the exception of telephone and data lines, shall be made in the name of Lessor only, and Lessor shall be solely liable for utility charges as they become due, including those for sewer, water, gas, electricity, and garbage removal.
- F. Compliance with Law.** Lessor shall, at its expense, comply with all applicable statutes, charters, laws, ordinances, building and maintenance codes, rules, regulations, requirements, and orders of duly constituted public authorities now or hereafter in any manner affecting the Premises, or the use thereof, or the sidewalks, alleys, streets, and ways adjacent thereto, whether or not any such statutes, charters, laws, ordinances, rules, regulations, requirements, or orders which may be hereinafter enacted involve a change of

policy on the part of the governmental body enacting the same. The Premises shall meet all current applicable code requirements, including but not limited to fire and life safety codes and the Americans with Disabilities Act Accessibility Guidelines.

6. Responsibilities of Lessee.

- A. Access to Premises.** Lessee shall permit Lessor or its agents to enter the portion of the Premises occupied by Lessee at all reasonable hours to inspect the Premises or make repairs, provided Lessee's use of the Premises shall not be unreasonably impaired.
- B. Non-assignment.** Neither Lessee nor its successors or assigns shall, without Lessor's consent, assign, mortgage, pledge, or encumber this Lease or sublet the Premises in whole or in part, or permit the Premises to be used or occupied by others, except as otherwise set forth herein.
- C. Surrender of Possession.** Upon termination of the Lease, Lessee shall peaceably and quietly surrender and deliver the Premises to Lessor, including all buildings, additions, and improvements constructed or placed thereon by Lessee in the same condition as they were received at the Commencement Date, with the exception of reasonable wear and tear arising from Lessee's use of the property for government business. Lessee shall maintain ownership of and may remove all moveable trade fixtures and cubicles supplied by Lessee. The Premises shall be free of sublessees on the Termination Date.

7. Special Provisions.

A. Alterations, Additions and Improvements.

- (i)** Lessee may, with the Lessor's prior written approval and at Lessee's own expense, at any time during the lease term, make nonstructural alterations, additions, or improvements in and to the Premises. Tenant Improvements are those improvements made by the Lessee to benefit Lessee's use of the Premises and may include adding cubicles, and modifying doorways to install security devices or locks. No structural or substantial portion of the Premises shall be demolished or removed by Lessee without the prior written consent of Lessor. Alterations shall be performed in a workmanlike manner and shall not weaken or impair the structural strength, or lessen the value, of the Premises.
- (ii)** Tenant Improvements shall only occur for purposes of Lessee's use of the Premises and not for general upgrade of the Premises or other aspects of the building or site upon and within which the leased Premises are located. Tenant Improvements are not intended to bring common areas, stairs, elevators, restrooms, ceilings, lighting, electrical, mechanical or plumbing up to code, and all such improvements to the property to comply with applicable building codes, the ADA, or to otherwise make the building and property useable for the purposes of this Lease, are the responsibility of Lessor and shall be completed in advance of the commencement of this Lease.

- (iii) No alterations, additions, or improvements requested by the agency occupying the Premises shall be undertaken without the express written consent of Lessor and Lessee. Lessee shall make the occupant agency aware of this provision and require the occupant agency to communicate any requests to Lessee. Lessor shall notify Lessee of any direct communications it receives from the occupant agency.
- (iv) All alterations, additions, and improvements on or in the Premises at the Commencement Date or erected or installed during the term, shall become part of the Premises and the sole property of Lessor, except that all moveable trade fixtures and cubicles installed by Lessee shall remain the property of Lessee.

B. Condition of Premises.

- (i) **Lessee:** Lessee has examined and knows the condition of the Premises to be leased.
- (ii) **Lessor:** Lessor agrees to provide the leased Premises in good order and repair. Lessor shall disclose all known contamination, hazardous conditions, or structural defects that may cause a safety issue. In the event Lessor fails to disclose any known contamination, hazardous conditions, or structural defects, Lessor shall have thirty (30) days to cure the defect(s) or agree on a written plan to cure said defects with Lessee. If defects are not addressed, Lessee may immediately terminate this Lease or withhold rent.

C. Destruction of Premises.

- (i) **Partial or Substantial Destruction.** In the event of partial destruction of the Premises, Lessee shall be entitled to a proportionate reduction of rent while repairs are being made by Lessor. The amount of the proportionate reduction shall be based on the extent to which the destruction and repairs interfere with the business carried on by Lessee. If the Premises are damaged by fire or other casualty which, in the opinion of Lessee, makes the Premises substantially unusable, the obligation to make payment under this Lease shall cease until the Premises are substantially usable by Lessee. Lessor is responsible for performance of all needed repairs unless otherwise agreed to in writing by Lessee.
 - a) **Repair.** Lessee and Lessor shall, as soon as reasonably practicable, prepare and sign a written itemized list of damages and required repairs, known as the "Substantial/Partial Destruction and Repair List." The list shall contain the following:
 - (1) Damage to be repaired by either Lessor or Lessee;
 - (2) Damage that will not be repaired; and
 - (3) The dates by which either Lessor or Lessee shall complete repairs.

- b) **Failure to Repair.** If the repairs, as specified in the Substantial/Partial Destruction and Repair List, are not completed within the time therein specified, or as otherwise mutually agreed upon by Lessee and Lessor, this Lease may be terminated or rent withheld by Lessee.
- (ii) **Total Destruction.** In the event of destruction of the Premises to such an extent that Lessee, in the opinion of Lessee, can no longer use the Premises, Lessee or Lessor shall be entitled to immediately terminate this Lease, and Lessee shall be entitled to withhold rent. In the event of termination, all pre-paid rents shall be promptly returned to Lessee.

D. Insurance.

- (i) **Governmental Entities.** Lessor and Lessee are each governmental entities of the State of Wyoming within the meaning of the Wyoming Governmental Claims Act, Wyo. Stat. § 1-39-101, et seq. (the “Act”). Each party shall comply with, and shall be bound by, the Act with respect to any claim, liability, loss, or damage arising out of or relating to this Lease or the Premises.
- (ii) **Coverage Consistent with the Act.** Each party shall provide for its liability obligations under this Lease through self-insurance, a governmental self-insurance program or risk pool, or commercial insurance, in each case as authorized by and consistent with the Act. No provision of this Lease requires either party to obtain or maintain insurance, or to accept liability, in an amount or manner greater than that authorized under the Act, and neither party’s procurement of any coverage shall be deemed a waiver of the limitations or immunities afforded by the Act.
- (iii) **Property/Liability Coverage.** Lessor shall be responsible for insuring the Building, the Premises, through the Wyoming Association of Risk Management and shall maintain liability insurance through the Wyoming Local Government Liability Pool (LGLP). The Lessee shall be self-insured for liability through the State Self-Insurance Program (SSIP). Lessee shall be responsible for obtaining insurance coverage for Lessee’s own personal property and contents located on the Premises and shall bear the risk thereto.
- (iv) **Control.** In the event of any conflict between this Lease and the Act, the Act shall control.

E. Maintenance and Repair.

- (i) Lessor, at its expense, shall be responsible at all times for maintaining and keeping in good repair, and replacing if necessary, all structural components of the property, building, and grounds thereof, including the roof, exterior walls, and floors of the Premises. Lessor shall be responsible for any costs associated with keeping in good repair all of the major building operating systems on the Premises, including, but not limited to, electrical systems, heating, ventilation, air conditioning systems,

sanitary sewer service lines, plumbing systems and lines, hot and cold water lines within the building, and restroom fixtures, but excluding all walls, light bulbs, and interior doors. Additionally, Lessor shall be responsible for any costs associated with keeping in good repair the exterior of the Building, including, but not limited to, that portion of the parking area owned by Lessee. Except as otherwise provided in this Lease, Lessor shall not be responsible for any damage caused by Lessee, the occupant agency, or its employees, agents, servants, invitees, contractors or subcontractors.

- (ii) Lessee shall not be responsible for maintenance or repair of the Premises, but shall in good faith endeavor to utilize the Premises in a responsible, prudent manner which does not give rise to abnormal or unusual repair costs for Lessor.

F. Easements, Contracts, or Encumbrances. The parties shall be bound by all existing easements, contracts, and encumbrances of record relating to the Premises.

8. General Provisions.

- A. Amendments.** Any changes, modifications, revisions, or amendments to this Lease which are mutually agreed upon by the parties to this Lease shall be incorporated by written instrument, executed and signed by all parties to this Lease.
- B. Applicable Law, Rules of Construction, and Venue.** The construction, interpretation and enforcement of this Lease shall be governed by the laws of the State of Wyoming, without regard to conflicts of law principles. The terms “hereof,” “hereunder,” “herein,” and words of similar import, are intended to refer to this Lease as a whole and not to any particular provision or part. The Courts of the State of Wyoming shall have jurisdiction over this Lease and the parties. The venue shall be the First Judicial District, Laramie County, Wyoming.
- C. Assignment Prohibited and Lease Shall Not be Used as Collateral.** Neither party shall assign or otherwise transfer any of the rights or delegate any of the duties set forth in this Lease without the prior written consent of the other party. The Lessor shall not use this Lease for collateral for any financial obligation without the prior written permission of the Lessee.
- D. Availability of Funds.** Each payment obligation of the Lessee is conditioned upon the availability of government funds which are appropriated or allocated for the payment of this obligation and which may be limited for any reason including, but not limited to, congressional, legislative, gubernatorial, or administrative action. If funds are not allocated and available for the continuance of this Lease, this Lease may be terminated by the Lessee at the end of the period for which the funds are available. Lessee shall notify the Lessor at the earliest possible time that the Lease will or may be affected by a shortage of funds. No penalty shall accrue to Lessee in the event this provision is exercised, and Lessee shall not be obligated or liable for any future payments due or for any damages as a result of termination under this provision.

- E. Counterparts.** This Lease may be executed in two or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same agreement.
- F. Entirety of Lease.** This Lease, consisting of twelve (12) pages, constitutes the entire Lease agreement between the parties and supersedes all prior negotiations, representations or contracts, whether written or oral.
- G. Force Majeure.** Neither party shall be liable for failure to perform under this Lease if such failure to perform arises out of causes beyond the control and without the fault or negligence of the nonperforming party. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, epidemics, quarantine restrictions, freight embargoes, and unusually severe weather. This provision shall become effective only if the party failing to perform immediately notifies the other party of the extent and nature of the problem, limits delay in performance to that required by the event, and takes all reasonable steps to minimize delays.
- H. Indemnification.** Each party to this Lease shall assume the risk of any liability arising from its own conduct. Neither party agrees to insure, defend, or indemnify the other.
- I. Independent Contractor.** The Lessor shall function as an independent contractor for the purposes of this Lease and shall not be considered an employee of the State of Wyoming for any purpose. Consistent with the express terms of this Lease, the Lessor shall be free from control or direction over the details of the performance of any services under this Lease. The Lessor shall assume sole responsibility for any debts or liabilities that may be incurred by the Lessor in fulfilling the terms of this Lease and shall be solely responsible for the payment of all federal, state, and local taxes which may accrue because of this Lease. Nothing in this Lease shall be interpreted as authorizing the Lessor or its agents or employees to act as an agent or representative for or on behalf of the State of Wyoming or the Lessee or to incur any obligation of any kind on behalf of the State of Wyoming or the Lessee. The Lessor agrees that no health or hospitalization benefits, workers' compensation, unemployment insurance or similar benefits available to State of Wyoming employees will inure to the benefit of the Lessor or the Lessor's agents or employees as a result of this Lease.
- J. Nondiscrimination.** The Lessor shall comply with the Civil Rights Act of 1964, the Wyoming Fair Employment Practices Act (Wyo. Stat. § 27-9-105, *et seq.*), the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, *et seq.*, and the Age Discrimination Act of 1975 and any properly promulgated rules and regulations thereto and shall not discriminate against any individual on the grounds of age, sex, color, race, religion, national origin, or disability in connection with the performance under this Lease.
- K. Notice.** All notices regarding termination or breach of contract shall be in writing. Communication regarding routine janitorial, maintenance, or repairs may be by telephone or email. With the exception of emergency communication regarding the safety or security

of the building occupants, all such communication and notices shall be between the Lessor and Lessee. Each notice for breach or termination shall be sent by registered or certified mail, postage prepaid and return receipt requested. Every notice shall be deemed to have been given at the time it shall be deposited in the United States mail in the manner prescribed herein. Nothing contained herein shall be construed to preclude personal service of any notice in the manner prescribed for personal service of a summons or other legal process.

i) Lessor's contact information is:

Sweetwater County
Gene Legerski
80 West Flaming Gorge Way
Green River, Wyoming 82935
307-872-3921
Email: legerskig@sweetwatercountywy.gov

ii) Lessee's contact information is:

Department of Administration & Information
General Services Leasing Division
Idelman Mansion
2323 Carey Avenue
Cheyenne, Wyoming 82002
307-777-2992
Email: ai-leasing@wyo.gov

iii) In the event that any of the above information changes, the party whose information has changed shall immediately notify the other party in writing.

L. Sovereign Immunity and Limitations. Pursuant to Wyo. Stat. § 1-39-104(a), the State of Wyoming and Lessee expressly reserve sovereign immunity by entering into this Lease and the Lessor expressly reserves governmental immunity. Each of them specifically retains all immunities and defenses available to them as sovereign or governmental entities pursuant to Wyo. Stat. § 1-39-101, *et seq.*, and all other applicable law. The parties acknowledge that the State of Wyoming has sovereign immunity and only the Wyoming Legislature has the power to waive sovereign immunity. Designations of venue, choice of law, enforcement actions, and similar provisions shall not be construed as a waiver of sovereign immunity. The parties agree that any ambiguity in this Lease shall not be strictly construed, either against or for either party, except that any ambiguity as to immunity shall be construed in favor of immunity.

M. Successors and Assigns. This Lease and the terms and conditions herein apply to and are binding on the purchasers, heirs, legal representatives, successors, assigns, agents and employees of both parties.

- N. Termination.** Lessee may terminate this Lease immediately for cause if Lessor breaches any provision of this Lease. Lessee shall provide written notice of the breach to Lessor and Lessor shall have five (5) calendar days, or a mutually agreeable longer period, to cure the breach. In addition to any termination for cause provided herein, Lessee may terminate this Lease without cause upon ninety (90) days written notice. In the event that Lessee should exercise its right to terminate this Lease by provision of written notice as above provided, all prepaid rents shall be promptly refunded to Lessee. Occupation of the Premises by Lessee for any part of a calendar month shall be deemed occupation for the entire month for the purpose of computing the refund.
- O. Third-Party Beneficiary Rights.** The parties do not intend to create in any other individual or entity the status of third-party beneficiary, and this Lease shall not be construed so as to create such status. The rights, duties and obligations contained in this Lease shall operate only between the parties to this Lease, and shall inure solely to the benefit of the parties to this Lease. The provisions of this Lease are intended only to assist the parties in determining and performing their obligations under this Lease.
- P. Time is of the Essence.** Time is of the essence in all provisions of this Lease.
- Q. Unlawful or Ultrahazardous Activity.** Neither party shall use or occupy the Premises or any part thereof for any unlawful or ultrahazardous purpose. A violation of this section by either party shall constitute sufficient grounds for immediate termination of this Lease by the non-violating party. Lessee agrees to use the Premises in full compliance with all federal, state, and local laws, ordinances, rules, and regulations.
- R. Waiver.** The failure by Lessor or Lessee to insist upon the strict performance of any term or condition of this Lease, or to exercise any right, power or remedy consequent upon a breach, shall not constitute a waiver of any prior or subsequent breach of such term or condition. A waiver of any breach shall not affect or alter this Lease, and each and every term and condition of this Lease shall continue in full force and effect regardless of any breach.

THE REMAINDER OF THIS PAGE WAS INTENTIONALLY LEFT BLANK

9. **Signatures.** The parties to this Lease, through their duly authorized representative, have executed this Lease on the dates set out below, and certify that they have read, understand, and agree to the terms and conditions of this Lease.

The Effective Date of this Lease is the date of the signature last affixed to this page.

LESSEE:

State of Wyoming, Department of Administration & Information, General Services Division

Andrew J. Kuhlmann, Administrator, General Services Division

Date

Patricia L. Bach, Director

Date

LESSOR:

Sweetwater County

Keaton D. West, Chairman

Date

Cynthia L. Swenson, County Clerk

Date

Lessor's Tax Identification Number:

ATTORNEY GENERAL'S OFFICE: APPROVAL AS TO FORM

Tyler M. Renner, Supervising Attorney General

Date



MEETING REQUEST FORM

Meeting Date Requested: July 21, 2026	Contact Phone and E-mail: 307-872-3910/mcleang@sweetwatercountywy.gov
Presenters Name, Title and Name of Organization: Garry McLean, Sweetwater County HR Director	Exact Wording for Agenda: 10:40- Request to add the auto excess coverage to the Summary Plan Description, effective January 1, 2026
Preference of Placement on Agenda & Amount of Time Requested for Presentation: 10 minutes	Will there be handouts? (If yes, include with meeting request form) Yes
Will handouts require SIGNATURES? Yes SHOULD THE ITEM BE MARKED CONFIDENTIAL? No	If you are submitting a Resolution or Proclamation, please forward in Word format to: shoemakers@sweetwatercountywy.gov
Additional Information:	
Attachments: 01-01-2026 Auto Excess Update Acceptance Letter.pdf PLAN 01-01-2026 02-01-2026 01-01-2025 00 - Auto Excess Update.pdf	

INSTRUCTIONS:

- All requests to be added to the agenda, along with handouts and original documents to be signed, must be submitted in writing on the “Meeting Request Form” by Tuesday at 10:00 a.m. prior to the scheduled meeting and returned in person or electronically to Administrative Assistant Sally Shoemaker at: shoemakers@sweetwatercountywy.gov
*****If your handout is not accompanied with the request, your request may be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- If you are presenting a **Resolution or Proclamation**, it must be submitted in Word Format and emailed to: shoemakers@sweetwatercountywy.gov
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item may be rescheduled.

- In order to determine placement on the agenda, please review the county website sweetwatercountywy.gov on Thursday afternoon by clicking “Commissioner's Agenda”.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.

The Board of County Commissioners meets in regular session the first and third Tuesday of every month.

The meetings are open and the public is invited to attend.

The meetings are held in the commission meeting room:

80 West Flaming Gorge Way

Meeting Room #115

Green River, Wyoming

[01-01-2026 Auto Excess Update Acceptance Letter.pdf](#)

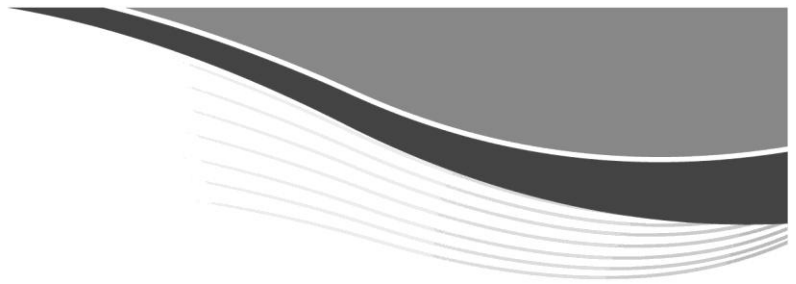
[PLAN 01-01-2026 02-01-2026 01-01-2025 00 - Auto Excess Update.pdf](#)



A UnitedHealthcare Company

115 W Wausau Ave
Wausau WI 54401-2875

PO Box 8046
Wausau WI 54402-8046



SWEETWATER COUNTY

May 5, 2026

Plan Number: 7670-00-411492

Dear Valued Customer:

With this letter, we are sending your modified Health summary plan description (SPD). This SPD, referred to as the plan document, will be the basis for the administration of your Health Plan.

Customized verbiage is identified in blue font throughout the document and remains as such to distinguish Plan owned language. Custom language is the responsibility of the Plan and not monitored by UMR for grammatical accuracy or compliance and regulatory appropriateness. It is the Plan's responsibility to monitor the language with each version of the SPD.

Also enclosed is the Acceptance Page, which formally approves the plan document. Please sign, retain a copy for your records, and return one copy to your UMR strategic account executive as soon as possible.

Note, however, that since the corresponding system changes have been implemented, this document is considered final, whether or not a signature is received. This document will be posted to the UMR employer web portal.

Book(s) will be posted to the UMR member web portal within 14 days of your receipt of the document. It is also important that the information in your formally approved plan document agrees with any material distributed to your employees since this document will contain the terms of plan coverage.

Any applicable stop loss policies typically rely on the last formally approved plan document when determining coverage. If the plan document distributed to your employees does not accurately describe the way your plan is actually being administered, the result can be a lapse or delay in stop loss coverage. **Important:** To prevent such lapses or delays in coverage, be sure to return the signed Acceptance Page to your UMR strategic account executive as soon as possible. If applicable, submit a copy of the Acceptance Page along with a copy of your current plan document to your stop loss carrier, which will constitute required notice of plan terms and conditions. Please keep a copy for your records.

If you have any questions, please contact your UMR strategic account executive.

Thank you for your business.

Traketa Simms
Case Installations
Enclosure

SUMMARY OF MODIFICATIONS

As requested, effective January 1, 2025, the following provision(s) were updated in, added to, or deleted from your Health Plan document. The change(s) are shaded in the plan document, with the exception of deleted wording:

- General Exclusions.
- Glossary of Terms.

ACCEPTANCE PAGE

Health Plan
7670-00-411492

SWEETWATER COUNTY acknowledges that we have reviewed the plan document effective January 1, 2025, and agree that the provisions contained in the plan document will be the basis for the administration of our Health Plan. The Plan Sponsor further represents that the plan document accurately reflects the intent of the Plan Sponsor and agrees that UMR may rely on such document in the administration of the Plan.

Accepted by the Plan Sponsor on _____
Date

Authorized Signature and Title
SWEETWATER COUNTY

FOR INTERNAL USE ONLY
CHIP #: 413462

SWEETWATER COUNTY GREEN RIVER WY

**Health Benefit Summary Plan Description
7670-00-411492**

Revised 01-01-2026

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

Table of Contents

INTRODUCTION.....	1
PLAN INFORMATION	2
MEDICAL SCHEDULE OF BENEFITS	4
MEDICAL SCHEDULE OF BENEFITS	6
MEDICAL SCHEDULE OF BENEFITS	14
MEDICAL SCHEDULE OF BENEFITS	22
MEDICAL SCHEDULE OF BENEFITS	30
MEDICAL SCHEDULE OF BENEFITS	38
TRANSPLANT SCHEDULE OF BENEFITS	45
TRANSPLANT SCHEDULE OF BENEFITS	46
TRANSPLANT SCHEDULE OF BENEFITS	47
PREScription SCHEDULE OF BENEFITS	48
PREScription SCHEDULE OF BENEFITS	49
PREScription SCHEDULE OF BENEFITS	50
PREScription SCHEDULE OF BENEFITS	51
PREScription SCHEDULE OF BENEFITS	52
CANCERCARE PROGRAM COVERAGE	53
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	55
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	56
OUT-OF-POCKET EXPENSES AND MAXIMUMS.....	58
ELIGIBILITY AND ENROLLMENT	60
SPECIAL ENROLLMENT PROVISION	64
TERMINATION	66
CONVERSION POLICY	68
COBRA CONTINUATION OF COVERAGE.....	69
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994	77
PROTECTION FROM BALANCE BILLING	78
PROVIDER NETWORK.....	80
COVERED MEDICAL BENEFITS	83
TELADOC HEALTH SERVICES	96
HOME HEALTH CARE BENEFITS.....	99
TRANSPLANT BENEFITS	100
PREScription DRUG BENEFITS.....	103
HEARING AID BENEFITS.....	104
BEHAVIORAL HEALTH BENEFITS	105
UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER	107

CENTERS OF EXCELLENCE.....	111
COORDINATION OF BENEFITS	112
RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET	116
GENERAL EXCLUSIONS	119
CLAIMS AND APPEAL PROCEDURES	125
FRAUD.....	134
OTHER FEDERAL PROVISIONS	135
HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION	137
PLAN AMENDMENT AND TERMINATION INFORMATION	141
GLOSSARY OF TERMS	142

SWEETWATER COUNTY
GROUP HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the SWEETWATER COUNTY Health Benefit Plan (the "Plan"). As a valued Employee of SWEETWATER COUNTY, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

SWEETWATER COUNTY is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and SmithRx for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

(Applies to Benefit Plan(s) 006) The Plan Administrator believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

80 W FLAMING GORGE WAY
STE 17
GREEN RIVER WY 82935
307-872-3910

You may also contact the U.S. Department of Health and Human Services at www.cciio.cms.gov.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document.

This document becomes effective on July 1, 2013.

PLAN INFORMATION

Plan Name	SWEETWATER COUNTY GROUP BENEFIT PLAN
Name And Address Of Employer	SWEETWATER COUNTY 80 W FLAMING GORGE WAY STE 17 GREEN RIVER WY 82935
Name, Address And Phone Number Of Plan Administrator	SWEETWATER COUNTY 80 W FLAMING GORGE WAY STE 17 GREEN RIVER WY 82935 307-872-3910
Named Fiduciary	SWEETWATER COUNTY
Employer Identification Number Assigned By The IRS	83-6000126
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	SWEETWATER COUNTY 80 W FLAMING GORGE WAY STE 17 GREEN RIVER WY 82935 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	January 1 through December 31

Compliance

It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 006

This Plan helps cover a portion of Medicare approved services, to the extent stated in this document. The information below will help explain how this Plan works, what the Covered Person's out-of-pocket costs will be, and how much this Plan will pay toward Covered Expenses.

All benefits payable from this Plan will be reduced by the amount that Medicare pays. This is referred to as non-duplication of benefits. Refer to the Coordination of Benefits provision in this document for more details.

Services must be Medically Necessary in order to be covered under this Plan.

YOUR OUT-OF-POCKET EXPENSES

COSTS YOU PAY (in addition to the monthly premium):
You are also responsible for paying for: • Services, products and procedures that are not covered by this Plan. • Any amount over the Usual and Customary charges, fee schedule or Negotiated Rates that this Plan pays for certain services, procedures or products. • Claims that are denied because they are not considered Medically Necessary as defined in this document.

COVERED EXPENSES

	This Plan Pays:
Lifetime Maximum Paid By This Plan (This does not include Prescription Benefits): • Per Person	Unlimited
Medicare-Approved Services Covered Under Medicare Part A (Subject To Any Limitations Medicare May Have): • Inpatient Hospital Stays, Semi-Private Room (Unless Private Room Is Medically Necessary), Meals, General Nursing, And Other Hospital Services • Skilled Nursing Facility Care, Semi-Private Room, Following A 3-Day Related Inpatient Hospital Stay • Blood You Get At A Hospital Or Skilled Nursing Facility During A Covered Stay • Inpatient Mental Health Care • Other Medicare-Approved Part A Services	• 100% of the Medicare-Approved amount for Part A services per Benefit Period. • 100% of the first three pints of blood that you receive each year as part of inpatient treatment.

	This Plan Pays:
Medicare-Approved Services Covered Under Medicare Part B (Subject To Any Limitations Medicare May Have): • Outpatient Hospital Care, Including Emergency Room Care • Ambulance Services • Doctor Office Visits • X-Rays, Laboratory And Diagnostic Tests • Anesthesia Services • Physical, Occupational And Speech Therapy On An Outpatient Basis • Routine Physical Exams Including Department Of Transportation (DOT) Physicals And Sports Physicals Are Covered. Limited To 1 Per Calendar Year Combined For All Covered Physical Exams (General Physical Exam, Sports Physical Or DOT Physical). • Annual Mammograms • Pap Smears, Pelvic Exam And Clinical Breast Exam • Prostate Cancer Screening • Colonoscopy, Flexible Sigmoidoscopy, And Fecal Occult Blood Test • Diabetes Services And Supplies • Annual Glaucoma Screening • Durable Medical Equipment Purchased From A Medicare-Approved Supplier • Kidney Dialysis • Transplants (Heart, Lung, Kidney, Pancreas, Intestine, Bone Marrow, Cornea, And Liver, When Performed At Medicare-Certified Facilities • Mental Health Care On An Outpatient Basis • Substance Use Disorder Outpatient Treatment • Braces For Arms, Legs, Back And Neck • Canes And Crutches • Cardiac Rehabilitation Program • Home Health Care Services • Chiropractic Services • Other Part B Services Approved By Medicare	• 100% of the Medicare-Approved amount for Part B services unless otherwise stated below. • 100% of the Medicare-Approved amount for Home Health Care services. • 100% of the Medicare-Approved amount for Outpatient mental health or Substance Use Disorder treatment. • 100% of the Medicare-Approved Part B amount for Durable Medical Equipment if payment is approved by Medicare. This Plan provides no coverage if Durable Medical Equipment is not approved for payment by Medicare. • 100% of the first three pints of blood that you receive each year. Once the Covered Person's out-of-pocket maximum requirement has been met, then this Plan will pay 100% of the remaining eligible expenses, up to the Lifetime Maximum.

NOTE: In the event that there is any conflict between Medicare regulations and this Plan Document, the Plan will follow Medicare rules for all Medicare-Approved services.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 011

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: - Per Person - Per Family	\$500 \$1,000	\$500 \$1,000
Plan Participation Rate, Unless Otherwise Stated Below: Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum: Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum. - Per Person - Per Family	\$2,500 \$5,000	\$5,000 \$10,000
Ambulance Transportation: Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services: Office Visit: - Co-pay Per Visit - Paid By Plan Manipulations: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$30 100% (Deductible Waived) \$30 20 Visits 100% (Deductible Waived)	\$30 100% (Deductible Waived) \$30 100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
X-Rays: - Co-pay Per Visit - Paid By Plan Visit Maximums Are Applied Based On Provider Designation And Procedure Code (If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation).	\$30 100% (Deductible Waived)	\$30 100% (Deductible Waived)
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: For Men: - Paid By Plan After Deductible For Women: - Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%
Durable Medical Equipment: Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment: Urgent Care: - Co-pay Per Visit - Paid By Plan Emergency Room / Emergency Physicians: - Paid By Plan After In-Network Deductible	\$30 100% (Deductible Waived) 80%	\$30 100% (Deductible Waived) 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: Paid By Plan After Deductible	80%	60%
Gender Dysphoria: - Paid By Plan After Deductible Travel And Lodging: - Maximum Benefit Per Calendar Year - Paid By Plan	80% \$2,000 100% (Deductible Waived)	60% No Benefit
Home Health Care Benefits: Paid By Plan After Deductible Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.	80%	60%
Hospice Care Benefits: Hospice Services: - Paid By Plan After Deductible Bereavement Counseling: - Maximum Visits Per Family Per Hospice Episode - Maximum Benefit Per Visit - Paid By Plan After Deductible	100% 100%	60% 15 Visits \$25 60%

Effective: 02-01-2026	IN-NETWORK	OUT-OF-NETWORK
Outpatient Or Partial Hospitalization Services And Physician Charges: • Paid By Plan After Deductible	80%	60%
Office Visit: • Co-pay Per Visit • Maximum Benefit Per Initial Visit • Maximum Benefit Per Subsequent Visit • Paid By Plan After Deductible	\$20 \$300 \$225 100% (Deductible Waived)	\$20 \$300 \$225 100% (Deductible Waived)
After Maximum Is Satisfied • Paid By Plan After Deductible	80%	80%
Physician Office Services: • Co-pay Per Visit – Primary Care Physician • Co-pay Per Visit – Specialist • Maximum Benefit Per Initial Visit • Maximum Benefit Per Subsequent Visit • Paid By Plan After Deductible	\$20 \$30 \$300 \$225 100% (Deductible Waived)	Not Applicable Not Applicable Not Applicable Not Applicable 60%
After Maximum Is Satisfied • Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: - From Age 7 Through 18 • Dollar Maximum Per Calendar Year - From Age 19 Through 40 • Dollar Maximum Per Calendar Year - From Age 41 Through 49 • Dollar Maximum Per Calendar Year 50 And Up • Dollar Maximum Per Calendar Year	Not Applicable Not Applicable Not Applicable Not Applicable	\$250 \$400 \$600 \$800
Preventive / Routine Physical Exams At Appropriate Ages: - From Age 7 • Maximum Exams Per Calendar Year • Paid By Plan	100% (Deductible Waived)	1 Exam 100% (Deductible Waived)
After Maximum Is Satisfied • Paid By Plan After Deductible	100% (Deductible Waived)	60%
Note: Department Of Transportation (DOT) Physicals And Sports Physicals Are Covered. Limit Of 1 Per Calendar Year Combined For All Covered Physical Exams (General Physical Exam, Sports Physical Or DOT Physical).		

	IN-NETWORK	OUT-OF-NETWORK
Immunizations: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible Foreign Travel Immunizations: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible Preventive / Routine Diagnostic Tests, Lab And X-Rays At Appropriate Ages: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible Preventive / Routine Mammograms And Breast Exams: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible Preventive / Routine Pelvic Exams And Pap Test: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived) Not Applicable 100% (Deductible Waived) 100% (Deductible Waived) Not Applicable 100% (Deductible Waived) 100% (Deductible Waived) Not Applicable 1 Exam 100% (Deductible Waived) 100% (Deductible Waived) Not Applicable 1 Exam 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60% 100% (Deductible Waived) 60% 100% (Deductible Waived) 60% 100% (Deductible Waived) 60% 100% (Deductible Waived) 60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine PSA Test And Prostate Exams: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Counseling For Alcohol And Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include: To Age 7 Preventive / Routine Physical Exams: • Paid By Plan Immunizations: • Paid By Plan Foreign Travel Immunizations: • Paid By Plan Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan Preventive / Routine Diagnostic Tests, Lab And X-Rays: • Paid By Plan	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	60% (Deductible Waived) 60% (Deductible Waived) 60% (Deductible Waived) 100% (Deductible Waived) 60% (Deductible Waived)
Sterilizations: For Men: • Paid By Plan After Deductible For Women: • Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%

	IN-NETWORK	OUT-OF-NETWORK
Supplemental Accident Expense Benefits - Including Dental Injuries: - Maximum Benefit Per Accident - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.	\$500 100% (Deductible Waived) 80%	100% (Deductible Waived) 60%
Teladoc Health Services: 24/7 Care: - Co-pay Per Occurrence - Paid By Plan Dermatology: - Co-pay Per Occurrence - Paid By Plan Mental Health: - Co-pay Per Occurrence - Paid By Plan Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.	\$10 100% (Deductible Waived) \$10 100% (Deductible Waived) \$10 100% (Deductible Waived)	
Telehealth: - Co-pay Per Visit – Primary Care Physician - Co-pay Per Visit – Specialist - Paid By Plan After Deductible	\$20 \$30 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Therapy Services: Occupational / Physical Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan Note: Medical Necessity Will Be Reviewed After 30 Visits.	\$20 40 Visits 100% (Deductible Waived)	\$20 100% (Deductible Waived)
Speech Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$20 20 Visits 100% (Deductible Waived)	\$20 100% (Deductible Waived)
Massage Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$30 20 Visits 100% (Deductible Waived)	\$30 100% (Deductible Waived)
All Other Covered Expenses: Paid By Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 012

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: - Per Person - Per Family	\$1,000 \$2,000	\$1,000 \$2,000
Plan Participation Rate, Unless Otherwise Stated Below: Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum: <i>Note: Medical, And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.</i> - Per Person - Per Family	\$3,000 \$6,000	\$6,000 \$12,000
Ambulance Transportation: Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services: Office Visit: - Co-pay Per Visit - Paid By Plan Manipulations: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$40 100% (Deductible Waived) \$40 20 Visits 100% (Deductible Waived)	\$40 100% (Deductible Waived) \$40 100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
X-Rays: - Co-pay Per Visit - Paid By Plan Visit Maximums Are Applied Based On Provider Designation And Procedure Code (If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation).	\$40 100% (Deductible Waived)	\$40 100% (Deductible Waived)
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: For Men: - Paid By Plan After Deductible For Women: - Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%
Durable Medical Equipment: Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment: Urgent Care: - Co-pay Per Visit - Paid By Plan Emergency Room / Emergency Physicians: - Paid By Plan After In-Network Deductible	\$40 100% (Deductible Waived) 80%	\$40 100% (Deductible Waived) 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: Paid By Plan After Deductible	80%	60%
Gender Dysphoria: - Paid By Plan After Deductible Travel And Lodging: - Maximum Benefit Per Calendar Year - Paid By Plan	80% \$2,000 100% (Deductible Waived)	60% No Benefit
Home Health Care Benefits: Paid By Plan After Deductible Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.	80%	60%
Hospice Care Benefits: Hospice Services: - Paid By Plan After Deductible Bereavement Counseling: - Maximum Visits Per Family Per Hospice Episode - Maximum Benefit Per Visit - Paid By Plan After Deductible	100% 100%	60% 15 Visits \$25 60%

Effective: 02-01-2026	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Imaging:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Physician Clinic Visits In An Outpatient Hospital Setting – Facility Claim:		
• Copay Per Visit	\$25	Not Applicable
• Paid By Plan After Deductible	100%	60%
Physician Clinic Visits In An Outpatient Hospital Setting – Physician Claim:		
• Copay Per Visit	\$25	Not Applicable
• Maximum Per Initial Visit	\$300	Not Applicable
• Maximum Per Subsequent Visits	\$225	Not Applicable
• Paid By Plan After Deductible	100%	60%
After Maximum Is Satisfied:		
• Paid By Plan After Deductible	80%	60%
Inpatient Occupational / Speech Rehab Therapy:		
• Maximum Days Per Calendar Year	45 Days	
• Paid By Plan After Deductible	80%	60%
Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

Effective: 02-01-2026	IN-NETWORK	OUT-OF-NETWORK
Mental Health And Substance Use Disorder Benefits: Inpatient Services / Physician Charges: Paid By Plan After Deductible	80%	60%
Residential Treatment: Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges: Paid By Plan After Deductible	80%	60%
Office Visit: - Co-pay Per Visit - Maximum Benefit Per Initial Visit - Maximum Benefit Per Subsequent Visit - Paid By Plan After Deductible	\$25 \$300 \$225 100% (Deductible Waived)	\$25 \$300 \$225 100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	80%	80%
Physician Office Services: - Co-pay Per Visit – Primary Care Physician - Co-pay Per Visit – Specialist - Maximum Benefit Per Initial Visit - Maximum Benefit Per Subsequent Visit - Paid By Plan After Deductible	\$25 \$40 \$300 \$225 100% (Deductible Waived)	Not Applicable Not Applicable Not Applicable Not Applicable 60%
After Maximum Is Satisfied Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
From Age 7 Through 18 Dollar Maximum Per Calendar Year	Not Applicable	\$250
From Age 19 Through 40 Dollar Maximum Per Calendar Year	Not Applicable	\$400
From Age 41 Through 49 Dollar Maximum Per Calendar Year	Not Applicable	\$600
50 And Up Dollar Maximum Per Calendar Year	Not Applicable	\$800

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Physical Exams At Appropriate Ages: From Age 7 - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Department Of Transportation (DOT) Physicals And Sports Physicals Are Covered. Limit Of 1 Per Calendar Year Combined For All Covered Physical Exams (General Physical Exam, Sports Physical Or DOT Physical).	1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Foreign Travel Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-Rays At Appropriate Ages: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Pelvic Exams And Pap Test: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Counseling For Alcohol And Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible *These Services May Also Apply To Men.	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Care Benefits For Children Include: To Age 7 Preventive / Routine Physical Exams: • Paid By Plan Immunizations: • Paid By Plan Foreign Travel Immunizations: • Paid By Plan Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan Preventive / Routine Diagnostic Tests, Lab And X-Rays: • Paid By Plan	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	60% (Deductible Waived) 60% (Deductible Waived) 60% (Deductible Waived) 100% (Deductible Waived) 60% (Deductible Waived)
Sterilizations: For Men: • Paid By Plan After Deductible For Women: • Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%

	IN-NETWORK	OUT-OF-NETWORK
Supplemental Accident Expense Benefits - Including Dental Injuries: - Maximum Benefit Per Accident - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.	\$500 100% (Deductible Waived) 80%	100% (Deductible Waived) 60%
Teladoc Health Services: 24/7 Care: - Co-pay Per Occurrence - Paid By Plan Dermatology: - Co-pay Per Occurrence - Paid By Plan Mental Health: - Co-pay Per Occurrence - Paid By Plan Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.	\$10 100% (Deductible Waived) \$10 100% (Deductible Waived) \$10 100% (Deductible Waived)	
Telehealth: - Co-pay Per Visit – Primary Care Physician - Co-pay Per Visit – Specialist - Paid By Plan After Deductible	\$25 \$40 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Therapy Services: Occupational / Physical Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan Note: Medical Necessity Will Be Reviewed After 30 Visits.	\$25 40 Visits 100% (Deductible Waived)	\$25 100% (Deductible Waived)
Speech Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$25 20 Visits 100% (Deductible Waived)	\$25 100% (Deductible Waived)
Massage Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$40 20 Visits 100% (Deductible Waived)	\$40 100% (Deductible Waived)
All Other Covered Expenses: Paid By Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 013

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible:		
• Per Person	\$1,500	\$1,500
• Per Family	\$3,000	\$3,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
<i>Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.</i>		
• Per Person	\$4,000	\$7,500
• Per Family	\$8,000	\$15,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services:		
Office Visit:		
• Co-pay Per Visit	\$45	\$45
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Manipulations:		
• Co-pay Per Visit	\$45	\$45
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
X-Rays: - Co-pay Per Visit - Paid By Plan Visit Maximums Are Applied Based On Provider Designation And Procedure Code (If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation).	\$45 100% (Deductible Waived)	\$45 100% (Deductible Waived)
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: For Men: - Paid By Plan After Deductible For Women: - Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%
Durable Medical Equipment: Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment: Urgent Care: - Co-pay Per Visit - Paid By Plan Emergency Room / Emergency Physicians: - Paid By Plan After In-Network Deductible	\$45 100% (Deductible Waived) 80%	\$45 100% (Deductible Waived) 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: Paid By Plan After Deductible	80%	60%
Gender Dysphoria: - Paid By Plan After Deductible Travel And Lodging: - Maximum Benefit Per Calendar Year - Paid By Plan	80% \$2,000 100% (Deductible Waived)	60% No Benefit
Home Health Care Benefits: Paid By Plan After Deductible Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.	80%	60%
Hospice Care Benefits: Hospice Services: - Paid By Plan After Deductible Bereavement Counseling: - Maximum Visits Per Family Per Hospice Episode - Maximum Benefit Per Visit - Paid By Plan After Deductible	100% 100%	60% 15 Visits \$25 60%

Effective: 02-01-2026	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Imaging:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Physician Clinic Visits In An Outpatient Hospital Setting – Facility Claim:		
• Copay Per Visit	\$30	Not Applicable
• Paid By Plan After Deductible	100%	60%
Physician Clinic Visits In An Outpatient Hospital Setting – Physician Claim:		
• Copay Per Visit	\$30	Not Applicable
• Maximum Per Initial Visit	\$300	Not Applicable
• Maximum Per Subsequent Visits	\$225	Not Applicable
• Paid By Plan After Deductible	100%	60%
After Maximum Is Satisfied:		
• Paid By Plan After Deductible	80%	60%
Inpatient Occupational / Speech Rehab Therapy:		
• Maximum Days Per Calendar Year	45 Days	
• Paid By Plan After Deductible	80%	60%
Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

Effective: 02-01-2026	IN-NETWORK	OUT-OF-NETWORK
Mental Health And Substance Use Disorder Benefits: Inpatient Services / Physician Charges: Paid By Plan After Deductible	80%	60%
Residential Treatment: Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges: Paid By Plan After Deductible	80%	60%
Office Visit: - Co-pay Per Visit - Maximum Benefit Per Initial Visit - Maximum Benefit Per Subsequent Visit - Paid By Plan After Deductible	\$30 \$300 \$225 100% (Deductible Waived)	\$30 \$300 \$225 100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	80%	80%
Physician Office Services: - Co-pay Per Visit – Primary Care Physician - Co-pay Per Visit – Specialist - Maximum Benefit Per Initial Visit - Maximum Benefit Per Subsequent Visit - Paid By Plan After Deductible	\$30 \$45 \$300 \$225 100% (Deductible Waived)	Not Applicable Not Applicable Not Applicable Not Applicable 60%
After Maximum Is Satisfied Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
From Age 7 Through 18 Dollar Maximum Per Calendar Year	Not Applicable	\$250
From Age 19 Through 40 Dollar Maximum Per Calendar Year	Not Applicable	\$400
From Age 41 Through 49 Dollar Maximum Per Calendar Year	Not Applicable	\$600
50 And Up Dollar Maximum Per Calendar Year	Not Applicable	\$800

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Physical Exams At Appropriate Ages: From Age 7 - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Department Of Transportation (DOT) Physicals And Sports Physicals Are Covered. Limit Of 1 Per Calendar Year Combined For All Covered Physical Exams (General Physical Exam, Sports Physical Or DOT Physical).	1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	100% (Deductible Waived)	60%
Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	100% (Deductible Waived)	60%
Foreign Travel Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Pelvic Exams And Pap Test: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
After Maximum Is Satisfied Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine PSA Test And Prostate Exams: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: Included In Maximum • Maximum Exams Per Calendar Year • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
Preventive / Routine Counseling For Alcohol And Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include: To Age 7 Preventive / Routine Physical Exams: • Paid By Plan Immunizations: • Paid By Plan Foreign Travel Immunizations: • Paid By Plan Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan Preventive / Routine Diagnostic Tests, Lab And X-Rays: • Paid By Plan	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	60% (Deductible Waived) 60% (Deductible Waived) 60% (Deductible Waived) 100% (Deductible Waived) 60% (Deductible Waived)
Sterilizations: For Men: • Paid By Plan After Deductible For Women: • Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%

	IN-NETWORK	OUT-OF-NETWORK
Supplemental Accident Expense Benefits - Including Dental Injuries: - Maximum Benefit Per Accident - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.	\$500 100% (Deductible Waived) 80%	100% (Deductible Waived) 60%
Teladoc Health Services: 24/7 Care: - Co-pay Per Occurrence - Paid By Plan Dermatology: - Co-pay Per Occurrence - Paid By Plan Mental Health: - Co-pay Per Occurrence - Paid By Plan Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.	\$10 100% (Deductible Waived) \$10 100% (Deductible Waived) \$10 100% (Deductible Waived)	
Telehealth: - Co-pay Per Visit – Primary Care Physician - Co-pay Per Visit – Specialist - Paid By Plan After Deductible	\$30 \$45 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Therapy Services: Occupational / Physical Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan Note: Medical Necessity Will Be Reviewed After 30 Visits. Speech Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$30 40 Visits 100% (Deductible Waived) \$30 20 Visits 100% (Deductible Waived)	\$30 100% (Deductible Waived) \$30 100% (Deductible Waived)
Massage Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$45 20 Visits 100% (Deductible Waived)	\$45 100% (Deductible Waived)
All Other Covered Expenses: Paid By Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 014

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible:		
• Per Person	\$4,000	\$4,000
• Per Family	\$8,000	\$8,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
<i>Note: Medical, And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.</i>		
• Per Person	\$6,000	\$9,000
• Per Family	\$12,000	\$18,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services:		
Office Visit:		
• Co-pay Per Visit	\$55	\$55
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Manipulations:		
• Co-pay Per Visit	\$55	\$55
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
X-Rays: - Co-pay Per Visit - Paid By Plan Visit Maximums Are Applied Based On Provider Designation And Procedure Code (If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation).	\$55 100% (Deductible Waived)	\$55 100% (Deductible Waived)
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: For Men: - Paid By Plan After Deductible For Women: - Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%
Durable Medical Equipment: Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment: Urgent Care: - Co-pay Per Visit - Paid By Plan Emergency Room / Emergency Physicians: - Paid By Plan After In-Network Deductible	\$55 100% (Deductible Waived) 80%	\$55 100% (Deductible Waived) 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: Paid By Plan After Deductible	80%	60%
Gender Dysphoria: - Paid By Plan After Deductible Travel And Lodging: - Maximum Benefit Per Calendar Year - Paid By Plan	80% \$2,000 100% (Deductible Waived)	60% No Benefit
Home Health Care Benefits: Paid By Plan After Deductible Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.	80%	60%

Effective: 02-01-2026	IN-NETWORK	OUT-OF-NETWORK
Hospice Care Benefits:		
Hospice Services:		
• Paid By Plan After Deductible	100%	60%
Bereavement Counseling:		
• Maximum Visits Per Family Per Hospice Episode • Maximum Benefit Per Visit • Paid By Plan After Deductible	100%	15 Visits \$25 60%
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges		
Room And Board Subject To The Payment Of		
Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Imaging:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Physician Clinic Visits In An Outpatient Hospital Setting – Facility Claim:		
• Copay Per Visit • Paid By Plan After Deductible	\$40 100%	Not Applicable 60%
Physician Clinic Visits In An Outpatient Hospital Setting – Physician Claim:		
• Copay Per Visit • Maximum Per Initial Visit • Maximum Per Subsequent Visits • Paid By Plan After Deductible	\$40 \$300 \$225 100%	Not Applicable Not Applicable Not Applicable 60%
After Maximum Is Satisfied:		
• Paid By Plan After Deductible	80%	60%
Inpatient Occupational / Speech Rehab Therapy:		
• Maximum Days Per Calendar Year • Paid By Plan After Deductible	80%	45 Days 60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Physical Exams At Appropriate Ages: From Age 7 - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Department Of Transportation (DOT) Physicals And Sports Physicals Are Covered. Limit Of 1 Per Calendar Year Combined For All Covered Physical Exams (General Physical Exam, Sports Physical Or DOT Physical).	1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Foreign Travel Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-Rays At Appropriate Ages: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Pelvic Exams And Pap Test: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Counseling For Alcohol And Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include: To Age 7 Preventive / Routine Physical Exams: • Paid By Plan Immunizations: • Paid By Plan Foreign Travel Immunizations: • Paid By Plan Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan Preventive / Routine Diagnostic Tests, Lab And X-Rays: • Paid By Plan	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	60% (Deductible Waived) 60% (Deductible Waived) 60% (Deductible Waived) 100% (Deductible Waived) 60% (Deductible Waived)
Sterilizations: For Men: • Paid By Plan After Deductible For Women: • Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%

	IN-NETWORK	OUT-OF-NETWORK
Supplemental Accident Expense Benefits - Including Dental Injuries: - Maximum Benefit Per Accident - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.	\$500 100% (Deductible Waived) 80%	100% (Deductible Waived) 60%
Teladoc Health Services: 24/7 Care: - Co-pay Per Occurrence - Paid By Plan Dermatology: - Co-pay Per Occurrence - Paid By Plan Mental Health: - Co-pay Per Occurrence - Paid By Plan Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.	\$10 100% (Deductible Waived) \$10 100% (Deductible Waived) \$10 100% (Deductible Waived)	
Telehealth: - Co-pay Per Visit – Primary Care Physician - Co-pay Per Visit – Specialist - Paid By Plan After Deductible	\$40 \$55 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Therapy Services: Occupational / Physical Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan Note: Medical Necessity Will Be Reviewed After 30 Visits.	\$40 40 Visits 100% (Deductible Waived)	\$40 100% (Deductible Waived)
Speech Outpatient Hospital And Office Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$40 20 Visits 100% (Deductible Waived)	\$40 100% (Deductible Waived)
Massage Therapy: - Co-pay Per Visit - Maximum Visits Per Calendar Year - Paid By Plan	\$55 20 Visits 100% (Deductible Waived)	\$55 100% (Deductible Waived)
All Other Covered Expenses: Paid By Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 015, 016

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year: Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible. - Per Person - Per Family	 \$1,700 \$3,400	 \$1,700 \$3,400
Plan Participation Rate, Unless Otherwise Stated Below: Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum: Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum. - Per Person - Per Family	 \$3,000 \$6,000	 \$6,000 \$12,000
Ambulance Transportation: Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps: Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services: Office Visit: - Paid By Plan After In-Network Deductible Manipulations: - Maximum Visits Per Calendar Year - Paid By Plan After In-Network Deductible	 80% 80%	 80% 20 Visits 80%

	IN-NETWORK	OUT-OF-NETWORK
X-Rays: • Paid By Plan After In-Network Deductible Visit Maximums Are Applied Based On Provider Designation And Procedure Code (If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation).	80%	80%
Contraceptive Methods Approved By The FDA And Contraceptive Counseling: For Men: • Paid By Plan After Deductible For Women: • Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%
Durable Medical Equipment: • Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment: Urgent Care: • Paid By Plan After In-Network Deductible Emergency Room / Emergency Physicians: • Paid By Plan After In-Network Deductible	80% 80%	80% 80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: • Paid By Plan After Deductible	80%	60%
Gender Dysphoria: • Paid By Plan After Deductible Travel And Lodging: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	80% \$2,000 100%	60% No Benefit
Home Health Care Benefits: • Paid By Plan After Deductible <i>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.</i>	80%	60%
Hospice Care Benefits: Hospice Services: • Paid By Plan After Deductible Bereavement Counseling: • Maximum Visits Per Family Per Hospice Episode • Maximum Benefit Per Visit • Paid By Plan After Deductible	100% 100%	60% 15 Visits \$25 60%

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Imaging:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Inpatient Occupational / Speech Rehab Therapy:		
• Maximum Days Per Calendar Year	45 Days	
• Paid By Plan After Deductible	80%	60%
Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%
Mental Health And Substance Use Disorder Benefits:		
Office Visit Only:		
• Paid By Plan After Deductible	80%	80%
Physician Office Visit:		
• Paid By Plan After Deductible	80%	60%
Physician Office Services:		
• Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
From Age 7 Through 18		
• Dollar Maximum Per Calendar Year	Not Applicable	\$250
From Age 19 Through 40		
• Dollar Maximum Per Calendar Year	Not Applicable	\$400
From Age 41 Through 49		
• Dollar Maximum Per Calendar Year	Not Applicable	\$600
50 And Up		
• Dollar Maximum Per Calendar Year	Not Applicable	\$800

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Physical Exams At Appropriate Ages: From Age 7 - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Department Of Transportation (DOT) Physicals And Sports Physicals Are Covered. Limit Of 1 Per Calendar Year Combined For All Covered Physical Exams (General Physical Exam, Sports Physical Or DOT Physical).	1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Foreign Travel Immunizations: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-Rays At Appropriate Ages: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Pelvic Exams And Pap Test: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: Included In Maximum - Maximum Exams Per Calendar Year - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 1 Exam 100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Counseling For Alcohol And Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: Included In Maximum - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived)	100% (Deductible Waived)
	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* Included In Maximum • Paid By Plan After Maximum Is Satisfied • Paid By Plan After Deductible	Not Applicable 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 60%
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include: To Age 7 Preventive / Routine Physical Exams: • Paid By Plan Immunizations: • Paid By Plan Foreign Travel Immunizations: • Paid By Plan Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Plan Preventive / Routine Diagnostic Tests, Lab And X-Rays: • Paid By Plan	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	60% (Deductible Waived) 60% (Deductible Waived) 60% (Deductible Waived) 100% (Deductible Waived) 60% (Deductible Waived)
Sterilizations: For Men: • Paid By Plan After Deductible For Women: • Paid By Plan After Deductible	80% 100% (Deductible Waived)	60% 60%

	IN-NETWORK	OUT-OF-NETWORK
Supplemental Accident Expense Benefits - Including Dental Injuries: - Maximum Benefit Per Accident - Paid By Plan After Maximum Is Satisfied - Paid By Plan After Deductible Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.	\$500 100% (Deductible Waived) 80%	100% (Deductible Waived) 60%
Teladoc Health Services: 24/7 Care: - Co-pay Per Occurrence - Paid By Plan Dermatology: - Co-pay Per Occurrence - Paid By Plan Mental Health: - Co-pay Per Occurrence - Paid By Plan Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.	\$10 100% (Deductible Waived) \$10 100% (Deductible Waived) \$10 100% (Deductible Waived)	
Therapy Services: Occupational / Physical Outpatient Hospital And Office Therapy: - Maximum Visits Per Calendar Year - Paid By Plan After In-Network Deductible Note: Medical Necessity Will Be Reviewed After 30 Visits. Speech Outpatient Hospital And Office Therapy: - Maximum Visits Per Calendar Year - Paid By Plan After In-Network Deductible Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service. Massage Therapy: - Maximum Visits Per Calendar Year - Paid By Plan After In-Network Deductible	40 Visits 80% 20 Visits 80% 20 Visits 80%	80% 80% 80%
All Other Covered Expenses: Paid By Plan After Deductible	80%	60%

TRANSPLANT SCHEDULE OF BENEFITS	
Benefit Plan(s) 006	
Transplant Services At A Designated Transplant Facility:	
Transplant Services:	
• Paid By Plan	100%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 011, 012, 013, 014	
Transplant Services At A Designated Transplant Facility: Transplant Services: • Paid By Plan After Deductible Travel And Housing: • Maximum Benefit Per Transplant • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	80% \$10,000 100% (Deductible Waived)

TRANSPLANT SCHEDULE OF BENEFITS	
Benefit Plan(s) 015, 016	

Transplant Services At A Designated Transplant Facility:	
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Transplant Services: • Paid By Plan After Deductible	80%
Travel And Housing: • Maximum Benefit Per Transplant • Paid By Plan After Deductible	\$10,000 100%
Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

• Paid By Plan After Deductible	80%
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- | | |
|----------------------------------|----------|
| Travel And Housing: | |
| • Maximum Benefit Per Transplant | \$10,000 |

• Maximum Benefit Per Transplant	\$10,000
• Paid By Plan After Deductible	100%

- | | |
|---------------------------------|------|
| • Paid By Plan After Deductible | 100% |
|---------------------------------|------|

- | | |
|---|--|
| Travel And Housing At Designated Transplant Facility
At Contract Effective Date/Pre-Transplant Evaluation
And Up To One Year From Date Of Transplant. | |
|---|--|

PRESCRIPTION SCHEDULE OF BENEFITS

Sweetwater County

Benefit Plan - 011

Annual Pharmacy Out-Of-Pocket Maximum Per Plan Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.</i> • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Nothing For Covered Prescription Medication.	\$2,500 \$5,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: \$7 Copay & 20% Coinsurance \$20 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance
Mail Order Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 90 Day Supply: \$14 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance \$80 Copay & 20% Coinsurance
Specialty Pharmacy • Covered Person's Co-Pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250
If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	

PRESCRIPTION SCHEDULE OF BENEFITS

Sweetwater County

Benefit Plan - 012

Annual Pharmacy Out-Of-Pocket Maximum Per Plan Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.</i> • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Nothing For Covered Prescription Medication.	\$3,000 \$6,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: \$7 Copay & 20% Coinsurance \$20 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance
Mail Order Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 90 Day Supply: \$14 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance \$80 Copay & 20% Coinsurance
Specialty Pharmacy • Covered Person's Co-Pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250
If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	

PRESCRIPTION SCHEDULE OF BENEFITS

Sweetwater County

Benefit Plan - 013

Annual Pharmacy Out-Of-Pocket Maximum Per Plan Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.</i> • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Nothing For Covered Prescription Medication.	\$4,000 \$8,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: \$7 Copay & 20% Coinsurance \$20 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance
Mail Order Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 90 Day Supply: \$14 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance \$80 Copay & 20% Coinsurance
Specialty Pharmacy • Covered Person's Co-Pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250
If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	

PRESCRIPTION SCHEDULE OF BENEFITS

Sweetwater County

Benefit Plan – 014

Annual Pharmacy Out-Of-Pocket Maximum Per Plan Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.</i> • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Nothing For Covered Prescription Medication.	\$6,000 \$12,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: \$7 Copay & 20% Coinsurance \$20 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance
Mail Order Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 90 Day Supply: \$14 Copay & 20% Coinsurance \$40 Copay & 20% Coinsurance \$80 Copay & 20% Coinsurance
Specialty Pharmacy • Covered Person's Co-Pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250 20% Copay to a Maximum of \$250
If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	

PRESCRIPTION SCHEDULE OF BENEFITS

Sweetwater County

Benefit Plan – 015, 016

Annual Pharmacy Deductible Per Plan Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Deductible Maximum</i> • Per Person • Per Family	\$1,700 \$3,400
Annual Pharmacy Out-Of-Pocket Maximum Per Plan Year: <i>Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.</i> • Per Person • Per Family Once The Annual Out-Of-Pocket Maximum Is Met, The Covered Person Pays Nothing For Covered Prescription Medication.	\$3,000 \$6,000
By Participating Retail Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible
Mail Order Pharmacy • Covered Person's Co-pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 90 Day Supply: 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible
Specialty Pharmacy • Covered Person's Co-Pay Amount • Generic drugs (Tier 1) • Preferred brand drugs (Tier 2) • Non-preferred brand drugs (Tier 3)	For Up To A 30 Day Supply: 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible
If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	

CancerCARE PROGRAM COVERAGE

The Plan provides coverage for evidence-based cancer care services provided at local, regional, and national cancer programs. The Plan employs INTERLINK's CancerCARE Program with specialized care coordination nurses, McKesson Clear Value Plus with Value Pathways powered by NCCN, and NCCN Clinical Practice Guidelines in Oncology. In order to be eligible for CancerCARE services, all Covered Persons with cancer diagnoses must call the CancerCARE Program at 877-640-9610 as soon as reasonably possible and complete registration.

DEFINITIONS

CancerCARE Program means a comprehensive cancer management program operated by INTERLINK, which employs care coordinator nurses to monitor and coordinate care at UnitedHealthcare-contracted Network Providers for appropriate Covered Persons.

National Comprehensive Cancer Network (NCCN) means an alliance of the nation's most prominent Hospitals that review outcome information for cancer treatments, publish evidence-based NCCN Guidelines, and update those guidelines as needed.

NCCN Guidelines means NCCN disease-specific, committee-recommended, evidence-based treatment processes for specific cancers with integrated drugs, dosing, and biologics recommendations.

Value Pathway means an optimal course of treatment created by the input of patient-specific clinical facts into the McKesson Clear Value Plus application, which utilizes NCCN Guidelines. Each Value Pathway has been based on efficacy, toxicity, and cost, providing value to the Covered Person and the Plan.

Network Provider means a cancer center, Hospital, or other institution, Physician, or ancillary provider that has been designated by the CancerCARE Program to provide complex cancer care services. Each provider must have a designation as a National Cancer Institute (NCI) Cancer Center or NCCN member institution and be a Network Provider within the UnitedHealthcare network.

Provider Referral means that, while CancerCARE provides benefits and support for all cancer diagnoses, Covered Persons with diagnoses or conditions that are considered rare, aggressive, or complex will be evaluated for referral to Network Providers. Such diagnoses or conditions are evaluated and determined by the CancerCARE Medical Team in consultation with a medical advisory board and other relevant medical literature. These diagnoses and conditions are reviewed and revised periodically. Please contact CancerCARE for details regarding which cancer diagnoses or conditions are currently considered rare, aggressive, or complex.

ADDITIONAL PROVISIONS

Registration Requirement. Upon diagnosis of cancer of any type, a Covered Person must call the CancerCARE Program at 877-640-9610 for registration into the program. Failure to register with the CancerCARE Program will prevent the Covered Person from receiving CancerCARE services.

CancerCARE Second Opinion. The Plan provides access to CancerCARE Second Opinion services, which may include a review of the diagnosis, review of the treatment plan, or both. A CancerCARE Second Opinion may require travel to a Network Provider. A CancerCARE Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services.

Clinical Trial Benefits. The Plan provides clinical trial coverage for routine patient costs consistent with the Qualifying Clinical Trials within the Covered Medical Benefits section.

The CancerCARE Program encourages a clinical trial to be: (1) provided at a Network Provider; and (2) an appropriate Phase I-IV clinical trial that has been coordinated by a CancerCARE Program nurse.

Covered Persons are encouraged to contact CancerCARE at 877-640-9610 for further information on clinical trial coverage.

Questions. If You have any questions regarding coverage or specific provisions of the CancerCARE Program, please contact the Plan Administrator or the CancerCARE Program at 877-640-9610.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Applies to Benefit Plan(s) 006

MONTHLY PREMIUMS

To receive coverage under this Plan, Covered Persons must pay the required monthly premium. The Plan Administrator will regularly advise Covered Persons of the required level of premiums that must be paid.

PLAN PARTICIPATION

Plan Participation means that, after Medicare pays primary. The Plan will pay a percentage of the Covered Expenses for the remainder of the Plan year, as shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 011, 012, 013, 014

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible.

If You have family coverage, any combination of covered family members may help meet the maximum family Deductible, up to each person's individual Deductible amount.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Negotiated Rate or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network and out-of-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person Incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person Incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

If You have family coverage, any combination of covered family members may help meet the maximum family out-of-pocket, up to each person's individual out-of-pocket amount.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 015, 016

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles. Co-pays do apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan. However, certain covered benefits may be considered Preventive / Routine Care and paid first dollar.

The Deductible amounts that the Covered Person incurs for Covered Expenses, including covered Pharmacy expenses, will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible.

If family coverage is elected, the full family Deductible amount must be met before the Plan will begin paying at the participation level.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Negotiated Rate or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual in-network and out-of-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

If family coverage is elected, the full family out-of-pocket amount must be met before the Plan will begin paying at the participation level.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

ELIGIBILITY REQUIREMENTS (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time [pursuant to the County policy and elected official, regardless of number of hours worked](#), but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased Employees.
- An Independent Contractor as defined in this Plan.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will be deemed to have met the eligibility requirements for the corresponding coverage period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage.

EMPLOYEE ELIGIBILITY (FORMER EMPLOYEES) (Applies to Benefit Plan(s) 006)

You are responsible for enrolling in the manner and form prescribed by Your former employer. Former employees are eligible for coverage under this Medicare Supplement Plan if all of the following requirements are met:

- You were enrolled in the active employee's health plan on the day before Your employment ended; and
- You retired from employment with SWEETWATER COUNTY under its formal retirement program, and You are eligible for Medicare.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. [A covered Employee's spouse who has group coverage available through his/her own employer must participate in that employer's coverage before he/she can be covered as a Dependent under this Plan. This does not apply to those couples who both work for Sweetwater County.](#)
- Your legal spouse and/or Dependents, upon the death of a pre-65 or post 65 Retiree after July 1, 2016, who is already enrolled in the Retiree plan, may remain on the Retiree plan for a maximum of 12 months, following the death of the Retiree. Coverage will continue to the earlier of:
 - [When premiums payment cease to be sent to the County for their portion of the benefits; or](#)
 - [The end of the 12th month following the death of the Retiree.](#)
- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:
 - A natural biological Child;
 - [A stepchild an Employee may enroll step-child\(ren\) under the County plan, however, if the Child\(ren\)'s parent has health insurance coverage offered through his/her employer, then the parent must cover the Children as primary coverage. The County plan will be secondary coverage.](#)
 - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
 - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
 - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
- A Dependent does not include the following:
 - A foster Child;
 - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;
 - A grandchild;
 - Domestic Partners;
 - Any other relative or individual unless explicitly covered by this Plan;
 - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 and over must [be incapable of self-sustaining employment due to mental or physical disability.](#)
- A Totally Disabled Dependent Child age 26 and over must be dependent upon the Employee for [primary support and maintenance.](#)
- A Totally Disabled Dependent Child age 26 and over must be unmarried.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month following Your date of hire; or
- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective July 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees).
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or
- July 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 31 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees. Covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be in the month of May. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage shall be July 1 following the annual open enrollment period.
- Retirees are not eligible for open enrollment period and will not be eligible to reenroll once the Retiree drops coverage or if coverage is terminated.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and
- The coverage under the other group health plan or health insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage is offered; or
 - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
 - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status. Retired Employees who are Covered Persons have a special opportunity to enroll newly acquired Dependents for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the first day of the month following the date of marriage (Note: Eligible individuals must submit their enrollment forms within **30 days** prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth. **The newborn Child will be effective on the date of birth for a period of 31 days. The Employee may continue coverage for the newborn Child beyond the 31-day automatic coverage provided that the completed application for coverage of the newborn Child is received by the Employer within 61 days of the Child's date of birth; or**
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption. **The adopted Child or legal ward will be effective on the date of birth for a period of 31 days. The Employee may continue coverage for the adopted Child or legal ward beyond the 31-day automatic coverage provided that the completed application for coverage of the adopted Child or legal ward is received by the Employer within 61 days of the earlier of the date of filing of the petition for adoption, or date the Child enters the adoptive home (unless the Child is in the custody of the State, in which case the effective date of coverage will be the date of the entry of a final adoption decree by the court.); or**
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following an approved request for coverage; or
- In the case of loss of coverage, the first day of the month following loss of coverage. **Employees must request or apply for coverage within 31 days.**

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The end of the stability period as defined by the Affordable Care Act (ACA) in which You became a member of a non-covered class, as determined by the employer except as follows:
 - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided that the applicable Employee contribution is paid when due.
 - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- Upon the death of a pre-65 or post 65 Retiree after July 1, 2016, an eligible spouse and/or Dependents, already enrolled in the Retiree plan may remain on the Retiree plan for a maximum of 12 months, following the death of the Retiree. Coverage will continue to the earlier of:
 - When premiums payment cease to be sent to the County for their portion of the benefits; or
 - The end of the 12th month following the death of the Retiree.
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section; or

- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Eligibility and Enrollment Section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all of the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

CONVERSION POLICY

When Your group coverage ends, You may have the right to enroll in an individual insurance policy. The benefits provided under an individual conversation policy may not be identical to those provided under Your current Plan. To find out more information regarding an individual policy You will need to contact the insurance carrier directly at:

UnitedHealthcare
P.O. Box 221709
Louisville, KY 40252
Phone Number: 866-747-1019
Email: icg.kyoperations@uhc.com

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

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 the coverage thru the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for 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.

The COBRA Administrator for this Plan is: BBP Admin

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

**BBP Admin
PO BOX 736230
CHICAGO IL 60673-6230
PHONE NUMBER: (630) 773-2337
FAX: (630) 775-8568**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the **first date of eligibility** the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her **30** days to send in a corrected check. If a corrected check is not received within the **30-day** timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be terminated from the Plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.
- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - Employee's death.
 - Employee's divorce or legal separation.
 - Former Employee becomes enrolled in Medicare.
 - A Dependent Child no longer being a Dependent as defined in the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the 18-month period and within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in case of a newborn Child being added as a result of a HIPAA Special Enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
SWEETWATER COUNTY
80 W FLAMING GORGE WAY
STE 17
GREEN RIVER WY 82935

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term “certain network facility” is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator’s reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
 - The reimbursement rate as determined by a state All Payer Model Agreement
 - The reimbursement rate as determined by state law.
 - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
 - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Physician may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
 - The reimbursement rate as determined by a state All Payer Model Agreement.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
 - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
 - The reimbursement rate as determined by a state All Payer Model Agreement.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
 - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider's balance bill.

PROVIDER NETWORK

Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016

The word "**Network**" means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

United Healthcare Options PPO Network

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.
- **The program for Transplant Services at Designated Transplant Facilities is:**

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- If there is not an In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 50 mile radius of the Covered Person's residence, then the Out-of-Network charges will be processed as In-Network charges so long as the Covered Person provides appropriate documentation.

- Urgent Care services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Out-of-network services when related to a Chiropractic Manipulation or Physical, Speech and/or Occupational Therapy are to be paid at the in-network level of benefit, including (but not limited to) office visits and x-rays.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 Days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post-acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call UMR within 30 Days prior to the effective date or within 30 Days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

If You meet the requirements for Continuity of Care under applicable law or Network contract, the In-Network benefit level may continue for certain medical conditions and timeframes despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents generally need to be under a continuing treatment plan by a provider or facility who was a member of the participating Network and:

- Undergoing a course of treatment for a serious and complex condition that is either:
 - An acute illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or

- A chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- Undergoing Inpatient or institutional care;
- Scheduled for non-elective surgical care, including necessary postoperative care;
- Pregnant and being treated; or
- Terminally ill and receiving treatment for such illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **3D Mammograms**, for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits.
2. **Abortions (Elective).**
3. **Allergy Treatment** including: injections, testing and serum.
4. **Ambulance Transportation:**
 - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
 - Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.
5. **Anesthetics and Their Administration** while You are in an Inpatient Hospital, or being treated on an Outpatient basis.
6. **Autism Spectrum Disorders (ASD) Treatment. (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)**

ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).
7. **Blood (Applies to Benefit Plan(s) 006)** that You get on an Inpatient or Outpatient basis.
8. **Braces (Applies to Benefit Plan(s) 006)** for arms, legs, back and neck.
9. **Breast Prostheses (Applies to Benefit Plan(s) 006)** (including a surgical brassiere) after a mastectomy.

10. **Breast Pumps and related supplies.** Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.
11. **Breast Reductions** if Medically Necessary.
12. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
13. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.
14. **Cardiac Rehabilitation** programs, if referred by a Physician, for patients who have:
 - had a heart attack in the last 12 months; or
 - had coronary bypass surgery; or
 - a stable angina pectoris.

Covered services include:

 - Phase I, while the Covered Person is an Inpatient.
 - Phase II, while the Covered Person is in a Physician-supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.
15. **Cataract or Aphakia Surgery (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.
16. **Cataract or Aphakia Surgery (Applies to Benefit Plan(s) 006).** See also eyeglasses.
17. **Chiropractic Treatment:** Manipulation of the spine to correct a subluxation.
18. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.
19. **Cleft Palate And Cleft Lip**, including Medically Necessary oral surgery and pre-graft palatal expanders.
20. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an Optum Health facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.
21. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

The following contraceptives will be processed under the medical Plan:

- Contraceptive mobile app subscription (e.g., Natural Cycles).
- Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
- Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

22. **Cornea Transplants** are payable at the percentage listed under “All Other Covered Expenses” on the Schedule of Benefits.
23. **Dental (Applies to Benefit Plan(s) 006):** A serious dental condition requiring Inpatient treatment or Outpatient treatment in a Hospital, a surgical day care unit, or a participating ambulatory surgical center will be covered for: Surgical removal of unerupted teeth or impactions in the bone; extraction of seven or more permanent teeth at one time; reduction of a fracture; gingivectomies involving two or more gum quadrants; excision of a tumor (except that a radicular cyst must involve the roots of three or more teeth). When these procedures can be performed safely in a dentist's office, there is no coverage under this Plan.
24. **Dental Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** include:
- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), including implants. Treatment must [begin within 90 days](#) and be completed [within 12 months](#) of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
 - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
 - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
25. **Diabetes Supplies and Services (Applies to Benefit Plan(s) 006):** Blood glucose test strips, blood glucose meter, lancet devices and lancets, glucose control solutions for checking the accuracy of test strips and monitors, diabetes self-management training from a Medicare-approved program. Other diabetic services as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare are covered.
26. **Diabetes Treatment (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016):** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.
27. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as any other Illness.
28. **Durable Medical Equipment (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** subject to all of the following:
- The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
 - The equipment must be prescribed by a Physician.
 - The equipment is subject to review under the UMR CARE section of this SPD, if applicable.
 - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
 - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.

- If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
 - due to the growth or development of a Dependent Child;
 - when necessary because of a change in the Covered Person's physical condition; or
 - because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse, misuse, loss, or theft, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
29. **Durable Medical Equipment (Applies to Benefit Plan(s) 006):** The equipment must be prescribed by a Physician for use in Your home. Durable Medical Equipment must be durable, used for medical reason, and must not usually be useful to someone who is not sick or injured. DME items can only be obtained from a supplier who accepts Medicare assignment. The amount that You pay can vary. Medicare requires that some equipment be rented, and other equipment must be purchased. The type of Durable Medical Equipment that Medicare may cover includes, but is not limited to: Air fluidized beds, blood glucose monitors, commode chairs, crutches, home oxygen equipment and supplies, hospital beds, infusion pumps, nebulizers, patient lifts to lift patient from a bed or wheelchair, suction pumps, traction equipment, walkers, and wheelchairs.
 30. **Emergency Room Hospital and Physician Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.
 31. **Emergency Room Hospital and Physician Services (Applies to Benefit Plan(s) 006)** when Your health is in serious danger. (Emergency services are generally not covered in foreign countries).
 32. **Emergency Services Provided in a Foreign Country**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits.
 33. **Extended Care Facility Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. The Covered Person must obtain prior authorization for services in advance. (Refer to the UMR CARE section of this SPD). The following benefits are covered:
 - Room and board.
 - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.
 34. **Eyeglasses (Applies to Benefit Plan(s) 006):** Following cataract surgery with an intraocular lens, the Plan will help pay for cataract glasses, contact lenses, or intraocular lenses provided by an optometrist, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare. Only standard frames are covered.
 35. **Eye Refractions** if related to a covered medical condition.
 36. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:
 - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
 - [Treatment of corns, calluses and toenails when at least part of the nail root is removed.](#)
 - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

37. **Gender Dysphoria:** Benefits for the Medically Necessary 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. Surgeries that alter physical appearance only and are not for the treatment of Gender Dysphoria are not covered by the Plan.

This Plan provides an allowance for reasonable travel and lodging expenses, up to the maximum listed on the Medical Schedule of Benefits, if any, for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their address, as reflected in our records, to receive the covered health services from an available Network provider. Lodging expenses are further limited to \$50 per night for the Covered Person, or \$100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. Travel and lodging reimbursements that exceed IRS limits may be subject to IRS codes for taxable income. If You would like additional information regarding travel and lodging, You may contact us at the telephone number on Your ID card.

38. **Genetic Counseling** based on Medical Necessity.
39. **Genetic Testing** when Medically Necessary (see below).

Genetic Testing MUST meet the following requirements:

The test is not considered experimental or investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

And must meet at least one of the following:

- The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
- Conventional diagnostic procedures are inconclusive.
- The patient has risk factors or a particular family history that indicate a genetic cause.
- The patient meets defined criteria that place them at high genetic risk for the condition.

Generally, genetic testing is not covered for:

- Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies
- Informational purposes alone (i.e., testing of minors for adult-onset conditions, and self-referrals or home testing)
- Test is considered Experimental or Investigational.

40. **Hearing Services** include exams, tests, services and supplies to diagnose and treat a medical condition.
41. **Home Health Care Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016):** (Refer to Home Health Care section of this SPD).
42. **Home Health Care Services (Applies to Benefit Plan(s) 006):** Intermittent skilled nursing care, physical therapy, speech language pathology services or occupational therapy services that You get in Your home for the treatment of an Illness or Injury. You must be considered homebound as defined by Medicare. The home health agency must be approved by the Medicare program.

43. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

- **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
- **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
- **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within 12 months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

44. **Hospital Services (Includes Inpatient Services, Surgical Centers And Inpatient Birthing Centers) (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016).** The following benefits are covered:

- Semi-private and private room and board services:
 - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
 - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable. Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

45. **Hospital Services (Includes Inpatient Services and Ambulatory Surgery Centers) (Applies to Benefit Plan(s) 006).** The following benefits are covered:

- Semi-Private Room and Board.
- Intensive Care Unit Room and Board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

46. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

47. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

48. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person.

Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

49. **Kidney Dialysis (Applies to Benefit Plan(s) 006)** as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

50. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

51. **Macular Degeneration (Applies to Benefit Plan(s) 006)** treatment for people with age-related macular degeneration. The treatment is referred to as ocular photodynamic therapy with verteporfin.

52. **Manipulations (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016):** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

53. **Marriage Counseling** that is part of a behavioral health treatment plan.

54. **Massage Therapy.** (See Therapy Services below)

55. **Maternity Benefits** for Covered Persons include:

- Hospital or Birthing Center room and board.
- Vaginal delivery or Cesarean section.
- Non-routine prenatal care.
- Postnatal care.
- Medically Necessary diagnostic testing.
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Midwives.

56. **Mental Health Treatment (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** (Refer to the Behavioral Health Benefits section of this SPD).

57. **Mental Health Treatment (Applies to Benefit Plan(s) 006)** needed on an Inpatient or Outpatient basis to help diagnose and treat mental health conditions, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

58. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

- Bariatric surgery, including, but not limited to:
 - Gastric or intestinal bypasses. (Roux-en-Y; Biliopancreatic bypass; Biliopancreatic diversion with duodenal switch)

Effective: 01-01-2025

- Stomach stapling. (Vertical banded gastroplasty; gastric banding; gastric stapling)
- Lap band. (Laparoscopic adjustable gastric banding)
- Gastric sleeve procedure. (Laparoscopic vertical gastrectomy; Laparoscopic sleeve gastrectomy)

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions of this SPD.

59. **Nursery And Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.
60. **Nutrition Therapy Services (Applies to Benefit Plan(s) 006)** for people with diabetes, kidney disease (if not on dialysis), and after a kidney transplant when referred by a Physician. Nutritional assessment, therapy and counseling can be provided by a registered dietician or Medicare-Approved nutrition professional.
61. **Nutritional Counseling** for preventive services that are required under the United States Preventive Services Task Force and/or for the treatment of medical and behavioral/mental health conditions.
62. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.
63. **Occupational Therapy.** (See Therapy Services below)
64. **Oral Surgery** includes:
- Excision of partially or completely impacted teeth.
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
 - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - Reduction of fractures and dislocations of the jaw.
 - External incision and drainage of cellulitis.
 - Incision of accessory sinuses, salivary glands or ducts.
 - Excision of exostosis of jaws and hard palate.
65. **Orthotic Appliances, Devices and Casts**, including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.
66. **Oxygen And Its Administration.**
67. **Oxygen Therapy (Applies to Benefit Plan(s) 006).** The Plan covers rental of oxygen equipment, or if You own Your own equipment, the Plan will help pay for oxygen contents and supplies for the delivery of oxygen if approved by Medicare. Portable oxygen is not covered when provided only as a backup to a stationary oxygen system.
68. **Pharmacological Medical Case Management** (Medication management and lab charges).
69. **Physical Therapy.** (See Therapy Services below)

70. **Physician Office Visits (Applies to Benefit Plan(s) 006)** for Medically Necessary services and covered preventive medical care.
71. **Physician Services** for covered benefits.
72. **Pre-Admission Testing.**
73. **Prescription Drugs (Applies to Benefit Plan(s) 006)** if approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare Part A, Part B.
74. **Prescription Medications (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.
75. **Preventive / Routine Care (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that 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;
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- Woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:
 - Screening for gestational diabetes;
 - Human papillomavirus (HPV) DNA testing;
 - Counseling for sexually transmitted infections;
 - Counseling and screening for human immune-deficiency virus;
 - Screening and counseling for interpersonal and domestic violence; and
 - Breast cancer genetic test counseling (BRCA) for women at high risk.

Please visit the following links for additional information:

<https://www.healthcare.gov/preventive-care-benefits/>
<https://www.healthcare.gov/preventive-care-children/>
<https://www.healthcare.gov/preventive-care-women/>

76. **Private Duty Nursing Services** when Inpatient care is required 24 hours a day.

77. **Prosthetic Devices (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016).** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

78. **Prosthetic Devices (Applies to Benefit Plan(s) 006)** needed to replace a body part or function, and as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

79. **Qualifying Clinical Trials** as defined below, including routine patient care costs as defined below 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.

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 may include:

- Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial;
- 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; and
- 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 that 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), including the *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 *Veteran's Administration* (VA);
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - 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:
 - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - It 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. The Plan Sponsor may, at any time, request documentation about the trial; or
- 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.

80. **Radiation Therapy and Chemotherapy.**

81. **Radiology and Interpretation Charges.**

82. **Reconstructive Surgery** includes:

- Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include 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 complications of mastectomies, including lymphedemas.
- Surgery to restore bodily function that has been impaired by a congenital illness or anomaly, Accident, or from an infection or other disease of the involved part.

83. **Respiratory Therapy.** (See Therapy Services below)

84. **Routine Care (Preventive Care) (Applies to Benefit Plan(s) 006)** to the extent approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

85. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

86. **Skilled Nursing Facility Care (Applies to Benefit Plan(s) 006):** The Plan will pay for care when a Covered Person is transferred to a Skilled Nursing Facility from a Hospital if:
- The Covered Person was hospitalized for 3 or more consecutive days, not including the day You leave the Hospital; and
 - You enter the Skilled Nursing Facility within 30 days after leaving the Hospital for the same or related reason that You were in the Hospital, as required by Medicare; and
 - Your doctor has stated that You need daily skilled care and that it must be provided by skilled nursing or rehabilitation staff.
87. **Sleep Disorders** if Medically Necessary.
88. **Sleep Studies.**
89. **Speech Therapy.** (See Therapy Services below)
90. **Sterilizations.**
91. **Substance Use Disorder Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** (Refer to the Behavioral Health Benefits section of this SPD).
92. **Substance Use Disorder Services (Applies to Benefit Plan(s) 006)** to the extent approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.
93. **Supplemental Accident Expenses Benefit** as shown on the Schedule of Benefits.
94. **Surgery and Assistant Surgeon Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** (See Modifiers or Reducing Modifiers above).
95. **Surgery and Assistant Surgeon Services (Applies to Benefit Plan(s) 006)** if determined Medically Necessary by the Plan. For multiple or bilateral procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. Unless there is a network contract, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure, and fifty percent (50%) of the Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.
96. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician. Consultations made by a covered Person to a Physician.
97. **Telemedicine. (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** (Refer to the Teladoc Health Services section of this SPD for more details.)
98. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:
- **Occupational therapy** by a Qualified occupational therapist.
 - **Physical therapy** by a Qualified physical therapist.
 - **Respiratory therapy** by a Qualified respiratory therapist.
 - **Massage therapy** by a Qualified chiropractor or a Qualified massage therapist (MT).

- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.
99. **Tobacco Addiction (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016):** Preventive / Routine Care as required by applicable law.
100. **Transplant Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** (Refer to Transplant section of this SPD).
101. **Transplant Services (Applies to Benefit Plan(s) 006)** means human to human transplant procedures which at the time sought to be provided are approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.
102. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.
103. **X-ray Services** for covered benefits.

TELADOC HEALTH SERVICES

(Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)

Note: Teladoc Health Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc Health may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc Health can be used for the following types of conditions:

- 24/7 Care general medicine, including, but not limited to:
 - Colds and flu
 - Allergies
 - Bronchitis
 - Pink eye
 - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc Health website, via the call center, or via the Teladoc Health mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc Health does not guarantee that every consultation will result in a Prescription. Medications are prescribed at the Physician's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after his or her consultation to call Teladoc Health with any clarification questions. A member of the Teladoc Health clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another Physician consultation, he or she will be charged the Teladoc Health consultation fee.

Teladoc Health may not be used for:

- Drug Enforcement Agency (DEA) controlled Prescriptions.
- Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc Health.

Dermatology Services Program

In addition to receiving care for general medical conditions, Covered Persons may receive access to dermatology services, as described below.

Dermatologists provide dermatology consultations to Covered Persons through an online message center using store-and-forward technology in the dermatology service area. The dermatology program offers Covered Persons the ability to upload photographs of their dermatological conditions to licensed dermatologists, who provide treatment and prescription medication, when appropriate. The dermatologists are selected and engaged to provide dermatological assessments in accordance with standard dermatology protocols and guidelines that are tailored to the telehealth industry.

In order to receive dermatology consultations, the Covered Person must have completed Teladoc Health's requirement for access to the general medicine program, including the medical history disclosure form. The Covered Person must also complete a comprehensive Dermatology Intake Form prior to receiving a dermatology consultation. The Dermatology Intake Form consists of a Dermatology History section and an intake form for the condition for which the Covered Person is seeking treatment describing the area of concern. This medical history and intake form may be completed either online or by telephone with a designated dermatology representative. Additionally, the Covered Person must upload at least three images of his or her condition prior to communicating with a dermatologist. If the Covered Person fails to complete the Dermatology Intake Form or upload the required number of images, the Covered Person will not have access to the dermatologists.

Covered Persons will be allowed to request more than one dermatology consultation at any given time. Dermatology consultations are not intended to be provided in Emergency situations.

Initial Consultation: The Covered Person will be required to upload a minimum of three images and a maximum of five images for the dermatologist to review. A dermatologist will respond to the Covered Person's consultation submission via the Teladoc Health Message Center within two business days of such submission. The dermatologist will either:

- determine that no additional information is required and provide a diagnosis and prescription, if appropriate; or
- request additional information from the Covered Person before making a diagnosis.

Covered Person Follow-Up: The Covered Person will have seven days after diagnosis to respond to the dermatologist with follow-up questions via the message center. The Covered Person will be able to respond only once and may upload up to five additional images in the response. The Covered Person will not be charged for a one-time follow-up.

Subsequent Consultations: A Covered Person will have the option of selecting the same dermatologist with whom he or she had a prior consultation or with a new dermatologist licensed in his or her state.

Mental Health Program

The Mental Health Program includes access to mental health Providers who provide mental health consultations to Covered Persons by telephone or video conference. The Mental Health Program offers Covered Persons ongoing access to mental health diagnostic services, talk therapy, and prescription medication management, when appropriate. The mental health Providers are selected and engaged to provide mental health clinical intake assessments in accordance with mental health protocols and guidelines that are tailored to the telehealth industry.

Mental Health Consultations: In order for a Covered Person to receive a mental health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Mental Health Program. This disclosure may be completed either online or by telephone with a designated Mental Health Program representative. In addition, the Covered Person must also agree to Teladoc Health's Informed Patient Consent and Release Form confirming an understanding that the mental health provider is not obligated to accept the Covered Person as a patient. If the Covered Person fails to complete the Medical History Disclosure, the Covered Person will not have access to the mental health providers through the Mental Health Program.

Scheduling: Teladoc Health will provide the Covered Person with information identifying each mental health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each mental health provider to allow the Covered Person to choose the provider from whom they wish to receive treatment. The Covered Person may schedule consultations through either Teladoc Health's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different mental health provider. There are no limitations on the number of mental health consultations a Covered Person may receive under the Mental Health Program.

Individual Sessions: The initial mental health consultation is expected to be 45 minutes in length, on average, followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the mental health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A mental health provider may determine that the treatment of a Covered Person's particular mental issue would be managed more appropriately through in-person therapy. In such a case, the mental health provider will encourage the Covered Person to make an appointment for an in-person visit.

Clarifications: Unlike the consultations provided under the 24/7 Care general medicine program, the mental health consultations under the Mental Health Program:

- Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a mental health consultation with a mental health provider and the consultation must occur within a time period for which the mental health provider is scheduled to support the Mental Health Program.
- Are not intended to be cross-coverage consultations. Rather, the Mental Health Program is designed to make mental health providers available by telephone or video conference even when another mental health counselor is available to the Covered Person for an in-person visit.
- Are not intended to be provided in Emergency situations.
- Are not available for Teladoc Health therapy for Covered Persons under the age of 13.
- Are not available for Teladoc Health psychiatry for Covered Persons under the age of 18.

HOME HEALTH CARE BENEFITS

Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietician.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a therapist or a registered dietician.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016

Refer to the UMR CARE section of this SPD for prior authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
 - Airfare.
 - Tolls and parking fees.
 - Gas/mileage.
- Lodging at or near the transplant facility including:
 - Apartment rental.
 - Hotel rental.
 - Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than \$50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by **SmithRx**

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. A Medicare-eligible individual generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay additional monthly penalties if they change their minds and sign up later. Medicare-eligible individuals should have received notices informing them of whether or not their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether or not election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

Covered Drugs

Your Prescription Drug benefit provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a Prescription." Your pharmacist or the prescribing Physician can verify coverage for a drug by contacting the Pharmacy Benefit Manager (PBM) at the number on Your Prescription ID card. A complete list of covered and excluded drugs may be available on the Pharmacy Benefit Manager's website. If You are unable to access the website, Your employer will provide a copy upon request at no charge.

How to Use the Prescription Drug Card

Present Your ID card and the Prescription to a Participating Pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the appropriate Co-pay amount, if applicable.

If You are without Your prescription ID card or if You are at a non-Participating Pharmacy, You may be required to pay for the Prescription and submit a claim to the PBM. Please contact the PBM or Your employer for information on how to submit a claim.

Home Delivery Drug Service

If You are using an ongoing Prescription drug, You may purchase that drug on a home delivery basis. Most drugs covered by the PBM may be purchased through the home delivery service. The home delivery drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis.

There may be a Co-pay for home delivery Prescriptions.

Home delivery Prescriptions should be sent to the PBM. Order forms may be available on the PBM's website or from Your employer. All Prescriptions will be mailed directly to Your home.

A directory of Participating Pharmacies is available on the PBM's website. You will also be automatically provided a copy of the pharmacy directory at no charge. The pharmacy directory is a document that is separate from this SPD. The directory contains the names, addresses, and phone numbers of the pharmacies that are part of the PBM's program.

HEARING AID BENEFITS

(Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-866-926-6632, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered and fitted by the provider.

In the event that You have questions about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-866-926-6632 or visit uhchearing.com.

BEHAVIORAL HEALTH BENEFITS

(Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

Covered Benefits

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide “residential” treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

Additional Provisions And Benefits

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

SUBSTANCE USE DISORDER BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

Covered Benefits

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Substance Use Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide “residential” treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

Additional Provisions And Benefits

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment, and all counseling or therapy notes, and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and at the appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. In general, when the Covered Person receives services from a Managed Care UnitedHealthcare Network Provider or facility, the provider or facility is responsible for obtaining the Prior Authorization. However, the Covered Person should ensure that the provider completes all required Prior Authorizations before services are rendered. If the Covered Person is not receiving covered health care services from a Managed Care UnitedHealthcare Network Provider, the Covered Person is responsible for ensuring that any required Prior Authorizations are completed before services are received. In that case, the Covered Person is responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for Medical Necessity review as required by the Plan. In addition to the requirement to notify and obtain Prior Authorization of a service or procedure in advance, all admissions to a facility also require a notification within 24 hours of the admission. If the stay is accessing a Managed Care UnitedHealthcare Network Provider, that facility must provide timely admission Notification (even if advance Notification was provided by the Physician and pre-service clinical approval is on file). If it is not a Managed Care UnitedHealthcare Network Provider the Covered Person is responsible for ensuring the facility completes that Notification.

Special Notes: A Covered Person who could reasonably expect that the absence of immediate, or Emergency, medical attention would jeopardize the life or long-term health of the individual is responsible for ensuring the provider contacts the Utilization Review Organization as soon as possible through the umr.com portal, by phone, or by fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Managed Care UnitedHealthcare Network Providers are providers participating in any UnitedHealthcare Network product with the exception of Options PPO.

Prior Authorization / Notification is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called “utilization review.” Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization at the number on the back of Your ID card or complete a Prior Authorization search at www.umar.com **before** a Covered Person receives services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or Durable Medical Equipment rentals over \$500.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- [Genetic testing \(PA not required for BRCA\).](#)

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount a Covered Person may be required to pay if an authorization has not been completed prior to receiving certain services or prior to admissions as defined in this section. A penalty of \$250 may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Medical Director Oversight. A UMR CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case management. Opportunities are identified by using system-integrated, automated, and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review may be conducted upon request or at the Plan's discretion, and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

CARE PROVISIONS

Digital Capabilities

Covered Persons in UMR CARE programs will have access to the CARE app, powered by Vivify. This app provides additional support to You when working with a CARE nurse. The nurse assigns a CAREpath related to Your condition that You work through together. In addition, this app provides health and wellness tips and insight into Your health conditions.

CARE Cues

CARE Cues features a digital solution for clinical gaps in care, including care for behavioral health and Substance Use Disorder. The CARE Cues program is integrated into a Covered Person's umr.com portal with notifications sent to the Covered Person's email that include next best action education and prompts to close the gap(s) in care.

There are over 150 digital gaps in care, including missed wellness / preventative opportunities, duplicative treatment, treatment disparities, condition management, immunizations, chronic condition drug interactions, and more. The email notifications will be offered to those Covered Persons with viable email addresses on file.

Complex Condition CARE

Complex Condition CARE is available to all Covered Persons. CARE nurse managers review available clinical information from utilization activity and other available resources to identify anticipated member needs. Collaboration with the member, caregiver, and provider is initiated to coordinate care in order to address gaps and barriers with the goal of reducing readmissions and/or complications. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.

Emerging CARE

Emerging CARE focuses on Covered Persons who are showing health behaviors that could lead to movement to a high-risk status. UMR CARE Coordinators will reach out via mailed letter or telephone to Covered Persons to assist them with health management. Outreach may be due to, but not limited to, frequent Emergency room visits, discharge support, Medical Specialty Medications, denial and appeal support, pre-surgical counseling for elective surgeries, and behavioral health/Substance Use Disorder member and family support.

Enhanced Behavioral Health CARE

Enhanced Behavioral Health CARE is designed to provide extended assistance for Covered Persons who can benefit from deeper behavioral health or Substance Use Disorder support. Our team of behavioral health registered nurses, social workers, and pharmacists are here to help program participants close gaps in care and improve self-management of their condition(s).

Our CARE team will also connect with Covered Persons after related Emergency room visits, Inpatient stays, and specific Outpatient services to ensure members are equipped with the tools and resources they need to self-manage their condition(s). Covered Persons who have behavioral health conditions or Substance Use Disorders can also self-enroll through the umr.com portal or by calling 1-800-207-3172.

Maternity CARE

Maternity CARE provides pre-pregnancy/pregnancy education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term Hospital stays for both mothers and babies. Program members are contacted by CARE nurses at least once each trimester and once postpartum. This program also offers an educational call and materials specifically to assist the participant's support person.

UMR's pre-pregnancy support program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, face risks not only to their babies, but also to themselves while they are pregnant.

Members can self-enroll in the Maternity CARE program by calling our toll-free number or enrolling online at www.umar.com. They are then contacted by CARE nurses who have extensive clinical backgrounds in obstetrics/gynecology.

CENTERS OF EXCELLENCE

Dialysis Network Services (DNS)

Dialysis Network Services (DNS) provides access to a preferred provider dialysis network and support from a UMR CARE Nurse Manager by collaborating with the Covered Person to delay the progression of the disease to renal failure.

UMR CARE End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

If a Covered Person chooses to seek services at a DNS preferred provider, the Covered Person must contact UMR CARE at 866-494-4502.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to Prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred. When a Covered Person has coverage under this Plan as both an Employee and a Dependent, then this Plan will internally coordinate benefits. **(Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** Prescription drug coverage will be coordinated under this Plan. **(Applies to Benefit Plan(s) 006)** Prescription drug coverage under Medicare Part D will be coordinated under the Medicare Secondary Payer Rules. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where an individual is covered under one plan as a Dependent and another plan as an Employee, member or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.
- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).
- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.
- If one or more plans cover the same person as a Dependent Child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.
 - **Dependent Children:** If an Employee's Dependent Child(ren) are covered under the County's health plan and also covered under the other parent's health plan, the health plan of the parent whose birthday occurs first in the year will be the primary plan. If a plan does not have this provision, the primary plan will be determined by the provision of the plan not having this paragraph.
 - **Stepchildren:** An Employee may enroll step-child(ren) under the County plan, however, if the Child(ren)'s parent has health insurance coverage offered through his/her employer, then the parent must cover the Children as primary coverage. The County plan will be secondary coverage.
- **Active or Inactive Employee:** If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
- **Continuation coverage under COBRA or state law:** If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
 - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
 - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
 - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
 - You are no longer actively employed by an employer; and
 - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or
 - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

- You or Your covered spouse have retiree coverage plus Medicare coverage; or
- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

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 Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, Your representative(s), Your Dependents, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will 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 allegedly related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness 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 Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, 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 an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity against whom You may have any claim arising out of any alleged wrongful or bad faith conduct by such person or entity.
- 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 that 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 our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our 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 Illness 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 that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our 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, no matter how those proceeds are allocated, captioned, characterized, or classified, and regardless of the theory of recovery. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, bad faith, and any other alleged 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, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will 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 will limit our 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 allegedly arising out of Illness or Injury and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will 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:
 - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
 - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
 - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.
- 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; 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.

- You may not accept any settlement that does not fully reimburse the Plan, without its 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 will 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 or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to a Dependent Child who allegedly incurs an Illness or Injury caused by a third party and to the parents, guardian, or other representative of that Dependent Child. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness 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 subscriber; 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 Illness 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 from third party recoveries 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 that 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.
- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

Effective: 01-01-2025

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **Abdominoplasty.**
2. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Acupuncture Treatment.**
4. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.
5. **Appointments Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy.**
7. **Assistance With Activities of Daily Living.**
8. **Assistant Surgeon Services,** unless determined Medically Necessary by the Plan.
9. **Auto Excess:** Illness or bodily Injury from a Motor Vehicle Collision for which there is a medical payment or expense provided or that is payable under any automobile coverage.
10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.
11. **Biofeedback Services.**
12. **Blood (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016):** Blood donor expenses.
13. **Blood Pressure Cuffs / Monitors.**
14. **Breast Pumps** unless covered elsewhere in this SPD.
15. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.
16. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.
17. **Claims** received later than 12 months from the date of service.

18. **Conditions Listed** in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases – Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:
 - Personality disorders; or
 - Behavior and impulse control disorders; or
 - “V” codes (refer to Marriage Counseling within the Covered Medical Benefits section of this SPD).
19. **Contraceptive Products and Counseling** unless covered elsewhere in this SPD.
20. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.
21. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan.
22. **Custodial Care** as defined in the Glossary of Terms of this SPD.
23. **Dental Services (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)**, unless covered elsewhere in this SPD.
24. **Developmental Delays:** Occupational, physical, or speech therapy services related to Developmental Delays, intellectual disability or behavioral therapy.
25. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.
26. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.
27. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
28. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.
29. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, or the Negotiated Rate. This exclusion does not apply to payments that may be required under the No Surprises Act.
30. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Benefits section of this SPD
31. **Extended Care (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016):** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.
32. **Family Planning:** Consultation for family planning.
33. **Financial Counseling.**
34. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

35. **Foot Care (Podiatry):** Routine foot care.
36. **Foreign Coverage for Medical Care Expenses, Which Includes Preventive Care or Elective Treatment,** except for services that are Incurred in the event of an Emergency. Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or Physician services in a provider's office, as shown in the Schedule of Benefits.
37. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.
38. **Genetic Testing** unless covered elsewhere in this SPD.
39. **Growth Hormones,** unless covered elsewhere in this SPD.
40. **Hearing Services:**
- Purchase or fitting of hearing aids.
 - Implantable hearing devices unless covered elsewhere in this SPD.
41. **Home Births** and associated costs.
42. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.
43. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.
44. **Infertility Treatment:**
- Fertility tests.
 - Surgical reversal of a sterilized state which was a result of a previous surgery.
 - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
 - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
 - Embryo transfer.
 - Freezing or storage of embryo, eggs, or semen.
 - Genetic testing.
- This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.
45. **Lamaze Classes** or other childbirth classes.
46. **Lasik Surgery, Radial Keratotomy, Refractive Keratoplasty (Applies to Benefit Plan(s) 006)** or similar surgery used to improve eyesight or refractive disorders.
47. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for the primary diagnosis of a Learning Disability. If another medical or behavioral/mental health condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
48. **Liposuction** regardless of purpose.

49. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.
50. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.
51. **Marriage Counseling**, unless covered elsewhere in this SPD.
52. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.
53. **Medicare (Applies to Benefit Plan(s) 006):** Charges for care and treatment of an Illness or Injury that is not approved by Medicare (except to the extent non-Medicare benefits are specifically provided for on the Schedule of Benefits).
54. **Military:** A military related Illness or Injury to a Covered Person on active military duty unless payment is legally required.
55. **Nocturnal Enuresis Alarm.**
56. **Non-Custom-Molded Shoe Inserts.**
57. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.
58. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.
59. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.
60. **Nutritional Counseling**, unless covered elsewhere in this SPD.
61. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.
62. **Orthognathic, Prognathic and Maxillofacial Surgery.**
63. **Orthopedic Shoes (Applies to Benefit Plan(s) 006).**
64. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.
65. **Palliative Foot Care.**
66. **Panniculectomy**, unless determined by the Plan to be Medically Necessary.
67. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.
68. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.
69. **Preventive / Routine Care Services** unless covered elsewhere in this SPD.

70. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.
71. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.
72. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
73. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.
74. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (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 members for self-infusion.
75. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.
76. **Services** that should legally be provided by a school.
77. **Services Provided By a Close Relative**, unless covered elsewhere in this SPD. See the Glossary of Terms section of this SPD for a definition of Close Relative.
78. **Sex Therapy.**
79. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.
80. **Skilled Nursing Care (Applies to Benefit Plan(s) 006):** Any Skilled Nursing Facility services which exceed the appropriate level of skill required for treatment as determined by the Plan.
81. **Standby Surgeon Charges.**
82. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.
83. **Surrogate Parenting and Gestational Carrier Services**, including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.
84. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.
85. **Telemedicine. (Applies to Benefit Plan(s) 006)**
86. **Temporomandibular Joint Disorder (TMJ) Services:**
- Diagnostic services.
 - Surgical treatment.
 - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

This does not cover orthodontic services.

- 87. **Tobacco Addiction:** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine unless covered elsewhere in this SPD.
- 88. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.
- 89. **Travel:** Travel costs, unless covered elsewhere in this SPD.
- 90. **Vision Care (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)** unless covered elsewhere in this SPD.
- 91. **Vision Care (Applies to Benefit Plan(s) 006):** Routine eye care or the purchase or fitting of eyeglasses or contacts, except as allowed by Medicare following cataract surgery.
- 92. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.
- 93. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.
- 94. **Warning Devices (Applies to Benefit Plan(s) 006):** Warning devices, stethoscope or other types of apparatus used for diagnosis or monitoring.
- 95. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.
- 96. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.
- 97. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.
- 98. **Workers' Compensation:** 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 employers that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners, and/or partners.
- 99. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan **before** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Negotiated Rate (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016): On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Negotiated Rate (Applies to Benefit Plan(s) 006): On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible or other out-of-pocket expenses that the Covered Person is responsible for, and subject to the Coordination of Benefits provision.

Modifiers or Reducing Modifiers (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016) if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- **Pre-Service Claim:** A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan if written notice is given to the Covered Person within the original 15-day period.
- **Post-Service Claims:** Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan if written notice is provided to the Covered Person within the original 30-day period.
- **Concurrent Care Claims:** If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- **Emergency and/or urgent care claims as defined by the Affordable Care Act:** The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or urgent care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan. **(Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)**

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, or Negotiated Rates.

- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.

- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After Your claim has been reviewed, You will receive written notification letting You know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide You with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
SMITHRX
PO BOX 994
LEHI UT 84043
[FAX \(PREFERRED\) 866-642-5620](tel:866-642-5620)

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW (Applies to Benefit Plan(s) 011, 012, 013, 014, 015, 016)

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the adverse benefit determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations relating to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:

- Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
- Whether a claim for items and services was furnished by a non-network provider at a network facility;
- Whether an individual gave informed consent to waive the protections under the No Surprises Act;
- Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
- Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse, or midwife, or a physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers 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 plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resource Director
Human Resource Specialist

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means 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 services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or
- Art therapy, music therapy, dance therapy, animal-assisted 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.

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

- In an Emergency situation; or
- When deemed Medically Necessary, which is to the closest facility most able to provide the specialized treatment required; and the most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Assignment (in the original Medicare Plan) means that the Covered Person's Part B provider has agreed to accept the Medicare-Approved amount as payment in full. The Covered Person still needs to pay any applicable Deductible and Plan Participation amounts. If a provider does not accept assignment, the Covered Person may pay more for services.

Benefit Period: A Benefit Period begins the day You go into a Hospital or skilled nursing facility, and ends when You haven't received any Hospital or Skilled Nursing Facility Care for 60 days in a row. If You go into the Hospital after one Benefit Period has ended, a new Benefit Period begins.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes a husband or wife, birth or adoptive parent, Child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee, Retiree or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible means the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Deductible Part A means the fixed amount that Medicare does not pay during the first 60 days of Hospital confinement per Benefit Period.

Deductible Part B means the fixed amount that You must pay each year before Medicare begins paying for Part B services.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.
- For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Limiting Charge means the highest amount of money You can be charged for a covered service by Physicians and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The Limiting Charge only applies to certain services and does not apply to supplies or equipment.

Lifetime Reserve Days means the 60 days that Medicare will pay for when the Covered Person is in a Hospital more than 90 days during a Benefit Period. These 60 reserve days can be used only once during the Covered Person's lifetime. For each Lifetime Reserve Day, Medicare will pay all covered costs except for the daily coinsurance amount.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, Substance Use Disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, Substance Use Disorder, disease or its symptoms; and

Effective: 01-01-2025

- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, disease, or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

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. We reserve 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 within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Medicare-Approved Amount means the fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by You and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "approved charge".

Mental Health Disorder means any disease or condition that falls under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopment disorders in the most 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 the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body Mass Index (BMI) of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Motor Vehicle Collision means an Accident that occurs when a motor vehicle strikes or collides with another vehicle, a stationary object, a pedestrian, or an animal with no implied determination of fault.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Outpatient Prospective Payment System means the system that Medicare uses to pay for services that the Covered Person receives at a Hospital, community mental health center and other facilities as an Outpatient.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the SWEETWATER COUNTY Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered or certified by the state in which the provider practices.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Skilled Nursing Facility Care means an institution that has a transfer agreement with one or more Hospitals. For the most part, it provides inpatients with skilled nursing care and related services. The facility must be licensed by the state in which it operates as a Skilled Nursing Facility. Any service that could be safely done by an average non-medical person (or by one's self) without the supervision of a registered nurse is not considered skilled care.

Substance Use Disorder means any disease or condition that falls under the diagnostic categories as a mental or behavioral disorder due to psychoactive substance use listed in the most 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 the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Diagnosis of one or more of the following conditions is not considered proof of total disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Diseases - Clinical Modification manual (ICD-CM) in the following categories:

- Personality disorders; or
- Sexual/gender identity disorders; or
- Behavior and impulse control disorders; or
- “Z” codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

You / Your means the Employee or Retired person.