BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0241 *Adopted Date* February 20, 2024

HIRE JADEN PICKETT AS CASE AIDE, WITHIN THE WARREN COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, CHILDREN SERVICES DIVISION

BE IT RESOLVED, to hire Jaden Pickett as Case Aide, within the Warren County Department of Job and Family Services, Children Services Division, classified, full-time permanent, non-exempt status (40 hours per week), Pay Grade #12, $19.45 per hour, under the Warren County Job and Family Services compensation plan, effective February 26, 2024, subject a negative drug screen, background check and a 365-day probationary period.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

H/R

cc: Children Services (file)
J. Pickett's Personnel file
OMB – Sue Spencer

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0242 *Adopted Date* February 20, 2024

ACCEPT RESIGNATION OF EVAN MAHLE, PROTECTIVE SERVICES CASEWORKER II, WITHIN THE WARREN COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, CHILDREN SERVICES DIVISION, EFFECTIVE FEBRUARY 16, 2024

BE IT RESOLVED, to accept the resignation, of Evan Mahle, Protective Services Caseworker II, within the Warren County Department of Job and Family Services, Children Services Division, effective February 16, 2024.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Children Services (file)
E. Mahle's Personnel File
OMB – Sue Spencer
Tammy Whitaker

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0243 *Adopted Date* February 20, 2024

APPROVING A SETTLEMENT PAYMENT REGARDING CHARGE NO #473-2024-00286 FILED WITH THE EQUAL OPPORTUNITIES COMMISSION

WHEREAS, the Warren County Probate Juvenile Court denies the allegations made in the charge, and further denies any fault, wrongdoing, liability, injury or damages arising from or during the employment of the claimant within Juvenile Probation Department of the Warren County Probate Juvenile Court; and

WHEREAS, an amicable settlement has been reached by the parties wherein Jessica Reed has agreed to accept in full and final settlement of all claims raised or which could have been raised, the sum of Thirty Thousand Dollars ($30,000) all terms of such agreement outlined in the Full, Final and Complete Release of All Claims, executed by claimant and attached hereto.

NOW THEREFORE BE IT RESOLVED, to approve the fully executed Full, Final, and Complete Release to All Claims; and

BE IT FURTHER RESOLVED, to approve payment to; Finney Law Firm Trust Account in the amount of $30,000.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

HR/

cc: c/a—Reed, Jessica
Commissioners File
Juvenile (File)
OMB (File)

FULL, FINAL, AND COMPLETE RELEASE OF ALL CLAIMS

This Full, Final, and Complete Release of All Claims is made by Jessica Reed, individually and on behalf of her heirs, representatives, successors, and assigns.

WHEREAS, Jessica Reed made claims with the Equal Employment Opportunities Commission under Charge No. 473-2024-00286 ("the Charge") against the Warren County, Ohio Probate-Juvenile Court (hereinafter "the Court") allegedly arising from and during Ms. Reed's employment with the Warren County Probate-Juvenile Court on and before July 19, 2021 and through her resignation on January 3, 2024; and

WHEREAS, the Court denies the allegations made in the Charge and further denies any fault, wrongdoing, liability, injury, or damages arising from or during the employment of Jessica Reed as a Juvenile Probation Officer with Warren County Probate-Juvenile Court; and

WHEREAS, an amicable settlement has been reached by the parties wherein Jessica Reed has agreed to accept in full and final settlement of all claims raise or which could have been raised (including any claims for attorney fees and costs), the sum of Thirty Thousand Dollars ($30,000.00) and an agreement by Warren County Probate-Juvenile Court to provide workplace harassment training to its management employees. By entering into such settlement, the Court does not admit the validity of such claims, but expressly denies any liability and any alleged damages.

NOW THEREFORE, Jessica Reed, individually and on behalf of her heirs, representatives, successors, and assigns, for an agreement by Warren County Probate-Juvenile Court to provide workplace harassment training to its management employees and for the total sum of Thirty Thousand Dollars ($30,000.00), the receipt, adequacy, and sufficiency of which is hereby acknowledged, does hereby release, acquit, and forever discharge Warren County, its commissioners, administrators, departments, agencies, directors, officials, and employees, its officers, insurers, and risk-sharing pools, agents, and assigns, both past and future; Warren County Probate-Juvenile Court, its administrators, departments, agencies, directors, officials, employees, agents, and assigns, both past and future; Judge Joseph Kirby, both individually and in his official capacity as Probate-Juvenile Court Judge and his heirs, executors, administrators, none of whom admit any liability to Jessica Reed but all expressly deny any liability, from any and all claims, actions, causes of action, demands, damages, rights, costs, expenses, compensation, interest, attorney fees, or suits at law or in equity, of any kind or nature whatsoever, and particularly on account of all damages or injuries, known or unknown, which have resulted or may in the future develop arising from Jessica Reed's employment with the Warren County Probate-Juvenile Court on and before July 19, 2021 and through her resignation on January 3, 2024.

FURTHER, for the above-referenced consideration, Jessica Reed agrees and directs and authorizes her attorney to dismiss with prejudice all claims dually made by her in the above-referenced Charge before the Equal Employment Opportunities Commission. This dismissal will

include and forever preclude any and all claims which have or could have been alleged in the Charge.

FURTHER, Jessica Reed agrees to satisfy from the settlement proceeds all outstanding medical expenses, liens, assigned claims, rights of reimbursement, attorney fees, and subrogated claims, if any. For the above-referenced consideration, the undersigned does also hereby specifically release, acquit, and discharge Warren County, Ohio, its commissioners, administrators, employees (past, present, and future), its insurers, and its agents and assigns, the Warren County Probate-Juvenile Court, its administrators, employees (past, present, and future), its insurers, and its agents and assigns, and Judge Joseph Kirby in both his individual capacity and in his capacity as Probate-Juvenile Court Judge, from any and all claims, demands, actions, liability, damages, judgments, or losses made against them as a result of any amount sought, claimed, or recovered by any insurer, person, governmental agency, or other organization or entity subrogated to the rights of the undersigned against them, or by any hospital, physician, or other health care provider of whatever kind with regard to the injuries or damages arising from or related to the described claims.

IT IS UNDERSTOOD AND AGREED by Jessica Reed that this settlement is a compromise of doubtful and disputed claims, that the payments made are not to be construed as an admission of liability on the part of any party, and that Warren County, Ohio and the Warren County Probate-Juvenile Court expressly denies any liability.

IT IS FURTHER UNDERSTOOD AND AGREED that this is a full and final release and satisfaction of all claims of the undersigned given in good faith, and discharging Warren County, Ohio, its commissioners, administrators, employees (past, present, and future), its insurers, and its agents and assigns, the Warren County Probate-Juvenile Court, its administrators, employees (past, present, and future), its insurers, and its agents and assigns, and Judge Joseph Kirby in both his individual capacity and in his capacity as Probate-Juvenile Court Judge from all claims of liability and intended to discharge Warren County, Ohio, the Warren County Probate-Juvenile Court, and Judge Joseph Kirby from any and all liability for contribution to any other alleged tortfeasor.

IT IS FURTHER UNDERSTOOD AND AGREED that this **FULL, FINAL, AND COMPLETE RELEASE OF ALL CLAIMS** has been voluntarily executed by the undersigned with the intent to bind the undersigned to the terms of this **FULL, FINAL, AND COMPLETE RELEASE OF ALL CLAIMS,** that the undersigned has been given a reasonable period of time within which to consider this settlement and its terms, that the terms of this settlement have been fully discussed with her attorneys, and that she has fully reviewed with her attorneys the legal claims and rights which are being released and her obligations under this **FULL, FINAL, AND COMPLETE RELEASE OF ALL CLAIMS.**

The undersigned **ACKNOWLEDGES** that this **FULL, FINAL, AND COMPLETE RELEASE OF ALL CLAIMS** contains and comprises the entire agreement and understanding of the parties to it, and that this agreement shall be interpreted, enforced, and governed by the laws of the State of Ohio.

THE UNDERSIGNED HAS READ THIS FULL, FINAL, AND COMPLETE RELEASE OF ALL CLAIMS, FULLY UNDERSTANDS IT, AND VOLUNTARILY EXECUTES IT SIGNIFYING HER ASSENT TO AND WILLINGNESS TO BE BOUND BY ITS TERMS.

STATE OF OHIO)
) **SS.**
COUNTY OF Clermont)

Jessica Reed

Sworn to before me and subscribed in my presence by Jessica Reed on this 9th day of February 2024, who signed the forgoing Full, Final, and Complete Release of All Claims and acknowledged to me that it was voluntarily signed.

Notary Public

My commission expires: _____

NOTARY PUBLIC STATE OF OHIO

EMMA FRIEDHOFF
Notary Public, State of Ohio
My Commission Expires
July 27, 2027

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0244 *Adopted Date* February 20, 2024

ACKNOWLEDGING AND ACCEPTING THE SUMMARY PLAN DESCRIPTIONS (SPD) AND PLAN CLARIFICATIONS RELATIVE TO THE BUY-UP AND BASE MEDICAL/RX PLAN FOR PLAN YEAR 2024

WHEREAS, from time to time the Summary Plan Descriptions require updates relative to adopted plan changes, and administrative process by United Healthcare, and other clarification to the language contained in the SPD; and

WHEREAS, from time-to-time updates and clarifications are needed to the plan documents and other information that pertains to the administration of the Warren County Self-Insured Healthcare Plan; and

WHEREAS, these plan clarifications include:

- If you waive medical/Rx coverage with Warren County, but are covered under another HDHP, you are not eligible to elect payroll deductions to your HSA through Warren County as Warren County cannot ensure that the other plan is compliant to the IRS HSA guidelines.

- You can, however, be enrolled in another High Deductible Health Plan (HDHP), such as your spouse's HDHP, and qualify for and contribute via payroll deduction to your own Health Savings Account (HSA) if you have elected a HDHP through Warren County; and

- The Plan cost tier selected must coincide with the family members that you enroll, otherwise OMB will make correction to reflect the appropriate cost that coincides with the family members enrolled.

NOW THEREFORE BE IT RESOLVED, to acknowledge and accept the Summary Plan Descriptions and plan clarifications relative to the Warren County Buy-Up and Base Medical/Rx Plan effective January 1, 2024, as attached hereto and made a part hereof.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

HR/

cc: United Healthcare
Horan Associates
Benefits File
Tammy Whitaker, OMB

Summary Plan Description

Warren County Board of Commissioners
Choice Plus HRA Plan

Effective: January 1, 20234
Group Number: 743289

TABLE OF CONTENTS

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Warren County Board of Commissioners is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Choice Plus HRA Plan works. If you have questions contact your local Office of Management & Budget department or call the number on your ID card.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week. In addition, you may be eligible for coverage even if you are not regularly scheduled 30 or more hours per week if you worked on average 30 or more hours per week during the Plan's "lookback measurement period".

AN ELECTED OFFICIAL (APPOINTED AUTHORITY) MAY ALSO EXTEND HEALTH AND LIFE INSURANCE (AS DEFINED IN C.F.R. 29, PART 541.1, 541.2, 541.3) IN THE UNCLASSIFIED SERVICE (I.E. ADMINISTRATIVE OR FIDUCIARY, AS DEFINEDIN ORC 124.11 A (9)) WITHOUT REGARD TO THE SCHEDULED NUMBER OF WORK HOURS OF SUCH EMPLOYEE, SUBJECT TO THE COMPLETION OF THIRTY (30) CONSECUTIVE CALENDAR DAYS OF EMPLOYMENT.

A former employee who has been rehired will be considered as a new employee, SUBJECT TO THE COMPLETION OF THIRTY (30) CONSECUTIVE CALENDAR DAYS OF EMPLOYMENT. If a former employee returns to full time employment within 13 weeks of prior employment, the former employee will not be subject to a 30 day witting period.

Formatted: Underline

Coverage is continued for Participant while on Active Military Duty. Warren County Board of Commissioners Plan will be primary.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*, your legal spouse, while not legally separated from you. Spouses who have access to an employer sponsored medical, dental, vision and/or prescription plan through their employer or through a retirement plan must be enrolled in that coverage in order to have coverage on this plan. The spouse would be eligible for secondary coverage under this plan. In order to insure proper claims processing, you will be required to provide your spouse's employment and insurance information to the Office of Management and Budget at the time of initial enrollment, subsequent annual group re-enrollment and when your spouse's employment changes.

You can obtain current contribution rates by calling Office of Management & Budget.

How to Enroll

To enroll, ~~call~~ contact the Office of Management & Budget within ~~3~~10 days from ~~of the~~ your hire date for your enrollment material ~~you first become eligible for medical Plan coverage~~. If you do not enroll within 31 days that you first become eligible for medical Plan coverage , you will need to wait until the next annual Open Enrollment to make your benefit elections.

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Underline, Not Strikethrough
Formatted: Not Strikethrough

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Office of Management & Budget within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Office of Management & Budget receives your properly completed enrollment, coverage will begin on the first day following the completion of a 30 day waiting period. Coverage for Late Enrollees will begin on the date identified by Warren County Board of Commissioners after Warren County Board of Commissioners receives the completed enrollment form and any required contribution for coverage. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

If you are rehired within 13 weeks of your termination of employment and you are eligible for coverage, your coverage will begin on your rehire date.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of that acquirement ~~first of the month following the date Office of Management & Budget receives notice of your marriage~~, provided you notify the Office of Management & Budget within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Office of Management & Budget within 30 days of the birth, adoption, or placement.

Formatted: Strikethrough

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Warren County Board of Commissioners' medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Warren County Board of Commissioners' medical plan outside of annual Open Enrollment.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

~~Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.~~

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Warren County Board of Commissioners or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-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 non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below 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 non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Network Benefits

Eligible Expenses are based on the following:

When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

For non-Emergency Covered Health Services received at certain Network facilities from 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 Health Service Act* with respect to a visit as defined by the Secretary, the Eligible Expense is based on one of the following in the order listed below 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 non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *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.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined, based on one of the following:

Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.

If rates have not been negotiated, then one of the following amounts applies based on the claim type:

Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:

- 50% of *CMS* for the same or similar freestanding laboratory service.
- 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:

- For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, the Claims Administrator will use a comparable scale(s). *UnitedHealthcare* and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to *UnitedHealthcare's* website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
- For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
- When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	No	No

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Annual Deductible[1] ■ Individual ■ Family (cumulative Annual Deductible[2]) ■ **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	~~$1,750~~2,000 ~~$3,500~~4,000	~~$3,500~~4,000 ~~$7,000~~8,000
Annual Out-of-Pocket Maximum[1] ■ Individual ■ Family (cumulative Out-of-Pocket Maximum[3]) **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.	~~$3,500~~4,000 ~~$7,000~~8,000	~~$7~~8,000 $14~~7~~6,000
Lifetime Maximum Benefit[4] There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]The Plan does not require that you or a covered Dependent meet the single Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the single coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

[3]The Plan does not require that you or a covered Dependent meet the single Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details.*

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
Ambulance Services ■ Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, How the Plan Works.	*Ground Ambulance* 90% after you meet the Annual Deductible *Air Ambulance* 90% after you meet the Annual Deductible	~~70% after you meet the Annual Deductible~~ *Ground Ambulance* Same as Network *Air Ambulance* Same as Network
■ Non-Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, How the Plan Works.	*Ground Ambulance* 90% after you meet the Annual Deductible *Air Ambulance* 90% after you meet the Annual Deductible	~~70% after you meet the Annual Deductible~~ *Ground Ambulance* Same as Network *Air Ambulance* Same as Network
Cellular and Gene Therapy Services must be received by a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under	Non-Network Benefits are not available.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	Non-Network
■ Orthotic Braces / Corrective Shoes See Section 6, *Additional Coverage Details*, for limits.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital within 24 hours of receiving outpatient Emergency treatment for the same condition, you will not have to pay this Copay, Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. ~~This does not apply to services provided to stabilize an Emergency after admission to a Hospital.~~ Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works.*	~~70~~90% after you meet the ~~Network~~ Annual Deductible	Same as Network
Fertility Preservation for Iatrogenic Infertility	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hearing Aids See Section 6, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care Up to 60 visits per calendar year	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	Non-Network
	nsive Outpatient Treatment after you meet the Annual Deductible	ensive Outpatient Treatment after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
	90% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	70% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Nutritional Counseling Up to three visits per condition per lifetime	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Obesity Surgery		
■ Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
See Section 6, *Additional Coverage Details* for limits		
~~**Orthopedic Surgeries**~~		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	Non-Network
■ Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Preventive Care Services		
■ Physician Office Services	100%	70% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests	100%	70% after you meet the Annual Deductible
■ Diagnostic Colonoscopy- age 45 and over	100%	70% after you meet the Annual Deductible
■ Breast Pumps	100%	70% after you meet the Annual Deductible
Prosthetic Devices	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures		
■ Physician's Office Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	Non-Network
Substance-Related and Addictive Disorders Services		
■ Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
	90% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	70% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation Services	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing transplant procedures	

Formatted Table

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from the Claims Administrator before you receive them, and any reduction in Benefits that may apply if you do not obtain prior authorization from the Claims Administrator.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

- 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. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; 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 which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; 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:

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises.

If you do not obtain prior authorization as required Benefits will be subject to a $250 reduction.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and

- Ketone test strips and tablets.
- Lancets and lancet devices.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).
If you fail to obtain prior authorization as required, Benefits will be subject to a $250 reduction.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital type bed;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces to include orthopedic shoes (standard or custom), lifts and wedges.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products – Outpatient* section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Any combination of Network Benefits and Non-Network Benefits is limited to $20,000 per lifetime.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete

Personal Health Support will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible.
If you fail to obtain prior authorization as required, Benefits will be subject to a $250 reduction.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.
If you fail to obtain prior authorization as required, Benefits will be subject to a $250 reduction.
In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization five business days before scheduled services are received.
If you fail to obtain prior authorization as required, Benefits will be subject to a $250 reduction.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or proceduresplanning;
- ~~Treatment and/or procedures.~~
- Medication management~~and other associated treatments~~.
- Individual, family and group therapy.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Any combination of Network Benefits and Non-Network Benefits is limited to $10,000 during the entire period you are covered under the Plan.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity surgery arises.
If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a $250 reduction.
In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.

~~Orthopedic Surgeries~~

~~Benefits for certain inpatient and outpatient orthopedic surgeries which are ordered by a Physician. Orthopedic surgical procedures including but not limited to the following:~~

- ~~Spine fusion and disc surgery.~~
- ~~Total joint replacement and joint revision surgeries.~~
- ~~Scopic procedures for joints.~~

~~Designated Network Benefits include Physician fees, the facility charge and the charge for supplies and equipment.~~

~~For all other Benefits, Physician fees are described under *Physician Fees for Surgical and Medical Services.*~~

~~Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, implant fees, DME and supplies and non-surgical management of orthopedic services will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits* table.~~

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient.*

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on your ID card.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $250 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly.

~~The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.~~

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly. ~~The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.~~

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Benefits are limited to:

- 60 visits per calendar year for physical, occupational and speech therapy combined;
- 20 visits per calendar year for cognitive rehabilitation therapy;
- 20 visits per calendar year for pulmonary rehabilitation therapy;
- 36 visits per calendar year for cardiac rehabilitation therapy; and
- Unlimited visits per calendar year for Manipulative Treatment;

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 90 days per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission you must provide notification as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $250 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

~~Spine and Joint Surgeries~~

~~Benefits for spine and joint surgeries which are ordered by a Physician. Spine and joint surgical procedures include the following:~~

- ~~Spine fusion surgery.~~
- ~~Spine disc surgery.~~
- ~~Total knee replacement.~~
- ~~Total hip replacement.~~

~~Designated Network Benefits include Physician fees, the facility charge and the charge for supplies and equipment.~~

~~*Spine and Joint Solutions Program*~~

~~For Designated Network Benefits, you must enroll in the *SJS Program* to receive services from a Designated Provider. To enroll you can call the Claims Administrator at the telephone number on your ID card or you can call the *SJS Nurse Team* at 888-936-7246.~~

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.
If you fail to obtain prior authorization as required, Benefits will be subject to a $250 reduction.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician when Medically Necessary. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow including CAR-T cell therapy for malignancies (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

If you don't obtain prior authorization as required, Benefits will be subject to a $250 reduction.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease Management Services;
- Complex Medical Conditions Programs and Services; and
- Wellness Programs;
- Women's Health/Reproductive.

Warren County Board of Commissioners believes in giving you the tools you need to be an educated health care consumer. To that end, Warren County Board of Commissioners has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Warren County Board of Commissioners are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to

Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

~~***Comprehensive Kidney Solution (CKS) program***~~

~~For Participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).~~

~~Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.~~

~~There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.~~

~~To learn more about Comprehensive Kidney Solutions, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.~~

~~Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.~~

Kidney Resource Services (KRS) program

End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging*, refer to the provision below.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below.

Your Plan Sponsor may provide you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the requisite distance from your home address to the facility is at least 50 miles. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the number on your ID card.

~~Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.~~

~~If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.~~

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.

- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a progmm participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Plan Benefits for Covered Health Services are described in Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*, under the *Schedule of Benefits*, unless the service is excluded in Section 8, *Exclusions and Limitations.*

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details.*

3. dental implants, bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details.*

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details.*

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details.* This exclusion does not apply to cranial molding helmets and cranial banding.

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter except as described

life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details.*

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details.*

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses.

2. tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations,* the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services,* and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details;*

- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - Sclerotherapy treatment of veins;
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. wigs regardless of the reason for the hair loss except for temporary loss of hair resulting from chemotherapy, and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition;

2. biofeedback;

3. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

4. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic

~~18~~17. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations;

~~19~~18. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment~~required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors or cancer or obstructive sleep apnea~~; and

~~20~~19. breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details.*

~~21~~20. Intracellular micronutrient testing.

~~22~~21. Cellular and Gene Therapy services not received from a Designated Provider.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

10. InVitro fertilization regardless of the reason for treatment.

11. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.~~Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility* in Section 6, *Additional Coverage Details.*~~

~~The following services related to a Gestational Carrier or Surrogate:~~

~~Fees for the use of a Gestational Carrier or Surrogate.~~

~~Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.~~

~~Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.~~

~~Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.~~

~~The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):~~

~~Known egg donor (altruistic donation i.e. friend, relative or acquaintance) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.~~

~~Purchased egg donor (i.e. clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.~~

~~Known donor sperm (altruistic donation i.e. friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.~~

~~Purchased donor sperm (i.e. clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.~~

~~Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility* in Section 6, *Additional Coverage Details.*~~

~~The reversal of voluntary sterilization.~~

~~Health care services and related expenses for surgical, non-surgical or drug induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).~~

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program ~~for the Covered Health Services described below~~* in Section 7, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants;

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;

2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

3. purchase cost and associated fitting charges for eyeglasses or contact lenses except for initial pair of eyeglasses post-cataract surgery;

4. eye exercise or vision therapy; and

- described as a Covered Health Service in this SPD under Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights;* and
- not otherwise excluded in this SPD under this Section 8, *Exclusions and Limitations.*

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details;*
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

11. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with us at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 10: Coordination of Benefits.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

determination letter. A request must be made within four months after the date you received Warren County Board of Commissioner's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO).* UnitedHealthcare has entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the *IRO.*
- A decision by the *IRO.*

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an *IRO* to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO*

maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by Warren County Board of Commissioners. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Warren County Board of Commissioners or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Warren County Board of Commissioners or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Warren County Board of Commissioners or the Claims Administrator.

You cannot bring any legal action against Warren County Board of Commissioners or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Warren County Board of Commissioners or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Warren County Board of Commissioners or the Claims Administrator.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary it determines the amount it will pay for a Covered Health Services by following the steps below.

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information?

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid, must make a refund to the Plan if:

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from Warren County Board of Commissioners to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to Warren County Board of Commissioners' staff, UnitedHealthcare's staff, a provider or another Covered Person.

You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: Warren County Board of Commissioners has the right to demand that you pay back Benefits Warren County Board of Commissioners paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Warren County Board of Commissioners proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Warren County Board of Commissioners' request, that the child continues to meet these conditions.

The proof might include medical examinations at Warren County Board of Commissioners' expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Warren County Board of Commissioners files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Office of Management & Budget with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information:*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Warren County Board of Commissioners and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Warren County Board of Commissioners and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Warren County Board of Commissioners and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and Warren County Board of Commissioners and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Warren County Board of Commissioners and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Warren County Board of Commissioners and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Warren County Board of Commissioners employees nor are they employees of UnitedHealthcare. Warren County Board of Commissioners and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Warren County Board of Commissioners is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- are responsible for choosing your own provider;

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Warren County Board of Commissioners and UnitedHealthcare with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. Warren County Board of Commissioners and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Warren County Board of Commissioners and UnitedHealthcare agree that such information and records will be considered confidential.

Warren County Board of Commissioners and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Warren County Board of Commissioners is required to do by law or regulation. During and after the term of the Plan, Warren County Board of Commissioners and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Warren County Board of Commissioners recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Warren County Board of Commissioners and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details.*
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction.*
- not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations.*

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);

- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator or as required by law as detailed in Section 3, *How the Plan Works.*

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.

- *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
- *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
- *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
- *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.

- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details.*
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and Warren County Board of Commissioners may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and Warren County Board of Commissioners must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) -- a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

~~**Intensive Outpatient Treatment** – a structured outpatient treatment program.~~

- ~~For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.~~
- ~~For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.~~

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Warren County Board of Commissioners. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and

Mental Health Services –services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator – the organization or individual designated by Warren County Board of Commissioners who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Warren County Board of Commissioners. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services ~~by way of their participation in the Shared Savings Program~~. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Warren County Board of Commissioners Medical Plan.

Plan Administrator – Warren County Board of Commissioners or its designee.

Plan Sponsor – Warren County Board of Commissioners.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on 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 Health Service Act.* For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *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.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or

- It provides a program of treatment under the active participation and direction of a Physician.

- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:

  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

~~**Residential Treatment** – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:~~

- ~~It is established and operated in accordance with applicable state law for Residential Treatment programs.~~
- ~~It provides a program of treatment approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.~~
- ~~Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;~~

  - ~~Room and board.~~
  - ~~Evaluation and diagnosis.~~
  - ~~Counseling.~~
  - ~~Referral and orientation to specialized community resources.~~

~~A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.~~

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

~~**Shared Savings Program** – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider and a third party vendor. When this program applies, the non-Network provider's billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare.~~

Behavioral Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Transitional Living – Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

Unproven Services – health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is Warren County Board of Commissioners, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201.

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏊ ᎰᏢ ᏗᏟᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏘᎳ ᏓᏥ ᏣᏙᏢ ᏙᎯ ᎰᎡ ᏗᏣᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏲᏎᏫᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	[illegible] 0 [illegible] TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Nl gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕیکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍ້ຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahnekl manaman unsek komwl en alehdi sawas oh mengihtik nl peln omwi tungoal lokaia nl soh Isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntinglhdi ni pein omwl doaropwe me pid koasoandl en kehl, padlk 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bááh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í la yínikeedgo, ninaaltsoos nit'iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77

Language	Translated Taglines
	fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Dum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܠܝܬ ܠܟ ܙܟܘܬܐ ܕܬܫܡܫ ܒܬܪܓܡܢܐ ܕܒܠܫܢܟ ܐܡ ܐܢܬ ܨܪܝܟ ܠܡܬܪܓܡ ܐܬܨܠ ܒܡܣܦܪ ܕܛܠܦܘܢ ܕܚܒܪ ܒܪܫܝܡܬܐ ܕܒܛܘܦܣ ܕܐܝܕܝ ܘܠܚܘܥ 0 ܠܡܫܡܥ ܠܟ ܒܫܘܠܡܐ ܘܒܚܝܐ ܠܟ ܒܪܝܫ ܟܪܛܝܣ ܕܐܝܕܝ ܕܐܢܬ ܚܒܝܫ ܠܗ ܒܗ ܒܐܬܪ ܕܐܢܬ ܒܥܐ ܠܡܫܡܥ ܠܟ ܒܫܘܠܡܐ ܘܒܚܝܐ ܠܟ ܒܪܝܫ ܟܪܛܝܣ ܕܐܝܕܝ ܕܐܢܬ ܚܒܝܫ ܠܗ ܒܗ ܒܐܬܪ ܕܐܢܬ ܒܥܐ TTY 711. 0 ܠܡܫܡܥ ܠܟ ܒܫܘܠܡܐ ܘܒܚܝܐ ܠܟ ܒܪܝܫ ܟܪܛܝܣ ܕܐܝܕܝ ܕܐܢܬ ܚܒܝܫ ܠܗ ܒܗ ܒܐܬܪ ܕܐܢܬ ܒܥܐ
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంటు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe anlnis ika toropwen aninis nge epwe awewetiw non

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.
UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final

External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- urgent care request for Benefits - a request for Benefits provided in connection with urgent care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.
You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

UnitedHealthcare

HSA Choice Plus Base Plan **Coverage for:** Family | **Plan Type:** PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-468-0980.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,500** Individual / **$7,000** Family Out-of-network: **$7,000** Individual / **$14,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan _____, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$7,000** Individual / **$14,000** Family Out-of-network: **$14,000** Individual / **$28,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2024 – 12/31/2024**

UnitedHealthcare

HSA Choice Plus Buy up Plan **Coverage for:** Family | **Plan Type:** PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-468-0980.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$2,000** Individual / **$4,000** Family Out-of-network: **$3,500** Individual / **$7,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$4,000** Individual / **$8,000** Family Out-of-network: **$7,000** Individual / **$14,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
HSA BASE Medical Plan

United HealthCare Services, Inc. and Warren County Board of Commissioners want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Single Coverage Deductible	$3,500 per year	$7,000 per year
Family Coverage Deductible	$7,000 per year	$14,000 per year
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Single Coverage Out-of-Pocket Maximum	$7,000 per year	$14,000 per year
Family Coverage Out-of-Pocket Maximum	$14,000 per year	$28,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Lifetime Maximum Benefit		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	No Lifetime Maximum Benefit	No Lifetime Maximum Benefit
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of *Prior Authorization*		
**Prior Authorization is required for certain services.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. • Embedded		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Durable Medical Equipment (DME) [1]		
	90% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
HSA BUY - UP Medical Plan

United HealthCare Services, Inc. and Warren County Board of Commissioners want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Single Coverage Deductible	$2,000 per year	$4,000 per year
Family Coverage Deductible	$4,000 per year	$8,000 year
• No one in the family is eligible for benefits until the family coverage deductible is met.		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Single Coverage Out-of-Pocket Maximum	$4,000 per year	$8,000 per year
Family Coverage Out-of-Pocket Maximum	$8,000 per year	$16,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Lifetime Maximum Benefit		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	No Lifetime Maximum Benefit	No Lifetime Maximum Benefit
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of Prior Authorization		
'Prior Authorization is required for certain services.		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. • Non-Embedded		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Durable Medical Equipment (DME) [1]		
	90% after Deductible has been met	** 70% after Deductible has been met

Warren County Healthcare Plan

2024

Presented By:

The Office of Management and Budget

on behalf of

The Board of County Commissioners

Tammy Whitaker
Benefits & Risk Manager
695-1324

Medical/Rx Benefits

- ***UnitedHealthcare*** (UHC) administers your medical coverage, and Choice Care Plus through UHC is the Preferred Provider Organization (PPO).

- ***OptumRx*** administers your prescription coverage.

  - NOTE: Warren County does not have a contract with Walgreen's Pharmacy.

- Once enrolled for benefits with ***UnitedHealthcare,*** you may register with ***myuhc.com*** to check your benefits, find doctors and hospitals, look up your claims, estimate costs ahead of time and learn about how to stay healthy.

Medical/Rx Benefits cont'd

For 2024, you will have the choice of two (2) medical plans:

High Deductible Health Plan
(HDHP Base Plan)

or

High Deductible Health Plan
(HDHP Buy-Up Plan)

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN (HDHP)?

- Federal law sets the minimum and maximum deductible and total-out-of-pocket range of the "HDHP".

- Co-pays and co-insurance do not apply to medical and prescription claims until the deductible has been met.

- Preventive care services can be provided as "first dollar benefits" which means that these services are not subject to the deductible.

The Board of Commissioners have adopted first-dollar coverage for preventive medication. This means preventive medication listed on the OptumRx preventive drug list will be covered at 100% - not subject to deductible!

Note* OptumRx updates the preventive drug list periodically, and this benefit provides coverage exclusive to the medications listed on the revision.

What is Warren County's HDHP 2024 Base Plan?

- This plan will require $0 contribution by you toward the premium.

- Based on this plan selection, employer contribution to Health Savings Account (HSA) -or- reimbursement to deductible under a Health Reimbursement Arrangement (HRA) does not apply.

- The Dental and Vision plans provided by Warren County remain stand alone plans. In other words, these services are not subject to and do not accumulate towards the HDHP deductible.

  - **The spousal parity provision of the healthcare plan requires that spouses must be enrolled in any medical, prescription, dental, and vision coverage that is available to them through their employer or their retirement. The Warren County Healthcare Plan will then provide secondary coverage.**

Base Plan Benefits Effective 1/1/2024 – 12/31/2024

(In-Network Benefits)

Deductible	$3500 – Individual $7000 – Family (embedded)
Co-Insurance	90%/10% After Deductible
Co-Insurance E/R	75%/25% After Deductible
Out-of-Pocket	$7000 – Individual $14000 – Family
Prescription Co-Pay	***After Deductible*** Tier 1: Generic – $10 Tier 2: Preferred – $35 Tier 3: Non-Preferred – $50 Tier 4: 25% to $250 maximum per fill **Preventive: 100% Paid (see pg. 5 for details)**

Embedded Deductible **– if any family member reaches the individual deductible then the deductible is satisfied for that individual. If any combination of family members reach the family deductible, then the deductible is satisfied for the entire family.**

What is Warren County's HDHP 2024 Buy-Up Plan?

- This plan will require a pre-tax contribution by you toward the premium for 26 pay periods in 2024.

EE (Employee) $ 41.49 - EE+Child(ren) $72.61 - EE+Spouse $93.35 - Family $124.47

- The employer will make a lump sum contribution of $300 single / $600 family into your HSA.
- For Sheriff's Office union employees, the employer will make two deposits twice annually $300 single / $600 family; January and July
- Certain employees not eligible for the HSA employer contribution may elect to receive a reimbursement to their deductible in this amount, contact OMB @ #1324 for details
- The dental and vision plans provided remain stand alone plans. In other words, these services are not subject to and do not accumulate towards the HDHP deductible.

The **spousal parity** provision of the healthcare plan requires that spouses must be enrolled in any medical, prescription, dental, and vision coverage that is available to them through their employer or their retirement. The Warren County Healthcare Plan will then provide secondary coverage. There is no cost difference to your premium whether spouse be primary or secondary under this plan.

Shared couples (when a married couple both work full-time for Warren County and eligible for the healthcare plan individually) will share the EE+Spouse or Family premium.

The cost tier selected above must coincide with the family members that you enroll, otherwise OMB will make correction to reflect the appropriate cost that coincides with the family members enrolled.

Buy-Up Plan Benefits Effective 1/1/2024 – 12/31/2024
(In-Network Benefits)

Deductible	$2000 – Individual $4000 – Family (non-embedded)
Co-Insurance	90%/10% After Deductible
Co-Insurance E/R	75%/25% After Deductible
Out-of-Pocket	$4000 – Individual $8000 – Family
Prescription Co-Pays	***After Deductible*** Tier 1: Generic – $10 Tier 2: Preferred – $35 Tier 3: Non-Preferred – $50 Tier 4: 25% to $250 maximum per fill **Preventive: 100% Paid (see pg. 5 for details)**

Non-Embedded Deductible – **expenses for all family members accrue toward the family deductible. One or more family members must satisfy the family deductible as a whole before medical expenses are reimbursed for any family member.**

Preventive Care

- Warren County's Preventive Care includes: Routine Physicals, Immunizations, and Labs. These services are not subject to the deductible and are paid at 100%.
- Coverage is provided at 100% for certain **routine** cancer screenings, such as: gynecological exam, mammogram, prostate screening, and colonoscopy.
- Certain women's health services and contraceptives are paid at 100%.
- The plan provides 100% payment for Warren County's Annual On-Site Blood Draw though CHC Wellbeing, and incents your participation with a day off work, "Dave's Day for Your Life"!
- A wellness contribution will be made to your HSA (or to an HRA if not eligible for an HSA) for your participation in the Wellness Incentive Program. Contact OMB for additional details.

Who is Eligible for HDHP?

- All Warren County employees who have satisfied the Plan's eligibility requirement: i.e., full-time, permanent employees are eligible for the Base -or- Buy-Up HDHP.

- However, although eligible for the HDHP, certain employees are not eligible for an HSA, the bank account that can be associated with the HDHP.

- *If you waive medical/rx coverage with Warren County, but are covered under another HDHP, you are not eligible to elect payroll deductions to your HSA through Warren County as Warren County cannot ensure that the other plan is compliant to HSA IRS guidelines.*

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

- An HSA is a bank account created exclusively for you and designed to help pay for current and future qualified health care expenses incurred by you, your spouse and your eligible dependents on a ***tax-free basis.***

- The maximum annual contribution to your HSA is assigned annually by the IRS. For 2024, the maximum contribution is:

  $4,150 – Single

  $8,300 – Family

- If you are age 55 or older, you can make a "catch-up" contribution of $1,000.

- You must reduce from these maximums by any employer contribution made to your HSA. Any employer contribution to your HSA is non-taxable to you.

How Does the Money Get Into My HSA?

- Through Employer Contributions. For 2024, if you have elected the Buy-Up Plan, Warren County will make one (1) direct contribution into your account. For future planning purposes, this contribution may end after 2024.

  Single Plan $300 January
  Family Plan $600 January

- Sheriff's Office Union Employees:

  Single Plan $300 January & July
  Family Plan $600 January & July

- ***If*** you have elected Base or Buy-Up Plan coverage, you have the option to make employee contributions that are deducted from your paycheck before it is taxed and deposited directly into your HSA. You designate the amount and have the opportunity to make a change to these amounts throughout the year. Contact OMB at ext. 1324 for a mid-year change form.

- You can make a direct deposit into your account, but this will require special tax reporting to ensure you get the tax reduction you are entitled to; it is recommended to speak with a tax advisor.

- Warren County utilizes ***1st National Bank*** to administer your HSA.

What Expenses Can be Paid Using HSA Dollars?

- Medical and prescription expenses applied toward your deductible, and co-insurance.
- Dental and vision expenses in excess of insurance payments.
- Eligible services not covered under the healthcare plan, unless considered cosmetic.
- Refer to the Internal Revenue Service for a general list of qualified expenses.

Receipt Requirements

Since your HSA is subject to IRS audit, save **ALL** Receipts, Bills and EOB's. Make sure this information includes:

1. Date of Service
2. Type of Service Provided
3. Service Provider's Name and Address
4. Amount you are responsible to pay

What Happens if I Misuse My HSA?

Since these accounts are subject to IRS audits, misuse may result in:

Excise tax applied
Income taxes applied
Interest and penalties applied

Note: Charges for services incurred prior to your enrollment in an HDHP and/or HSA are not eligible expenses payable from your HSA.

What Happens to My HSA if I Leave Employment Here?

- Your HSA is portable – it goes with you! You do not lose the money in your account.
- You can continue to make withdrawals for qualified expenses.
- You can continue to invest your money and draw interest on your balances.
- You cannot make new contributions to the account unless you become enrolled in another HDHP.

Who Is Not Eligible for an HSA?

You are not eligible to open or contribute to a previously established HSA ***if*** any of the following apply:

- You are enrolled in *Medicare.
- If you are enrolled in *TRICARE coverage through the military.
- If you use VA benefits (certain exceptions apply, contact OMB at #1324).
- If you are enrolled in a non-HDHP through your spouse or another source, such as a traditional type medical plan through your retirement.
- If you are claimed as a dependent on someone else's tax return.
- If you are enrolled in a Full Flexible Spending Account, ***or*** whose spouse is enrolled in a Full Flexible Spending Account.

Note:

- You can, however, be enrolled in another High Deductible Health Plan (HDHP), such as your spouse's HDHP, *and qualify for and contribute via payroll deduction to your own Health Savings Account (HSA) if you have elected a HDHP through Warren County.*

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OPTION

Buy-Up Plan Only

- ***If*** you are not eligible to contribute or receive contribution to an HSA due to your Medicare or TriCare enrollment, or medical benefits through the VA, or coverage through your own retirement plan enrollment; you may qualify for a reimbursement of a portion of your deductible, this is called an HRA (Health Reimbursement Arrangement).

Single – first $300 of your $2000 deductible
Family – first $600 of your $4000 deductible

Sheriff's Office union employees:

Single – first $600 of your $2000 deductible
Family – first $1200 of your $4000 deductible

Contact Tammy Whitaker at ext. 1324 for information on how this reimbursement process works.

How Does HDHP & HSA Work Together When I Go to the Doctor?

- Show your insurance card when you go to the doctor. This will allow United Healthcare to track your deductible for you and will also ensure you receive the network discount.

- If asked to pay a "co-pay" or "co-insurance" at the doctor's office, simply ask them to bill the claim while you are satisfying your deductible. When your deductible has been satisfied, it is then appropriate to pay the co-insurance for an applicable co-insurance service.

- Once your claim is billed and processed, you will receive an EOB (Explanation of Benefits) from United Healthcare.

HOW DOES THIS WORK WHEN I GO TO THE DOCTOR? CONT'D.

- You will also receive a bill from the provider. Make sure this bill reflects any network discount and matches the member responsibility on your EOB.

- Pay the bill from your HSA account if the balance is sufficient –OR–

- Pay the bill from your personal account and allow your HSA balance to grow.

- Retain Your Receipt!

How Does HDHP & HSA Work Together at the Pharmacy?

- Show your ***UHC/OptumRx*** insurance card at the pharmacy.
- The pharmacist will enter your insurance information and any ***OptumRx*** **n**etwork discount will be automatically applied.
- Pay for your prescription with your HSA debit card or by another means of your choice.
- The amount you pay will be transmitted to United Healthcare to be applied toward your deductible.
- Retain Your Receipt!
- Once your deductible is satisfied, you will automatically be converted to a co-pay system when filling future prescriptions.

Dental Benefits

Your dental benefits are cost free to you and provide the following annual per person coverage:

- ***$1,500*** annual maximum
- $50 deductible for basic or major services per person
- 100% payment on oral exams and cleanings twice per year (*paid from the $1,500 annual maximum*)
- 80% payment for basic services
- 50% payment for major services
- 60% payment to $2400 lifetime max for ortho benefits to age 19

Dental Care Plus is the administrator of your dental benefits.

You have the choice of one plan, a PPO plan.

Dental Benefits Cont'd.

PPO Plan

A PPO plan allows to use both In-Network and Out-of-Network providers.

Use of an in-network provider entitles you to network discounts. These discounts allow your maximum benefit to go farther and cost you less out-of-pocket because your responsibility is based on the discounted amount rather than the billed amount.

If you use an out-of-network provider, you will receive insurance payment up to the stated % based on reasonable & customary rates. You are not entitled to any discount, and in some cases your provider may bill you for the difference between the reasonable & customary rate and the billed amount.

Note: Most out-of-pocket dental expense you incur beyond insurance payment, other than cosmetic services, are an eligible expense under your HSA.

Vision Benefits

Your vision benefits will be administered by ***EyeMed InSight Network*** and are cost free to you, payable up to the following limits per person per year:

In-Network		Out-Of-Network
Eye Exam (per calendar year)	$10 co-pay	$40 allowance
Prescription Lenses ***or*** Contact Lenses per calendar year:		
Single Vision	$25 co-pay	$30 allowance
Bifocal	$25 co-pay	$50 allowance
Trifocal	$25 co-pay	$70 allowance
Contact Lenses	$130 allowance	$104 allowance
Frames (every 2 calendar years)	***$170*** Allowance	$91 allowance

Additional In-Network Discounts May Apply

NOTE: Most out-of-pocket vision expense incurred beyond insurance payment, other than cosmetic services, are eligible expenses under your HSA.

Group Life Insurance

- Benefits are provided through ***Minnesota Life Insurance Company.***
- A cost-free benefit.
- For most employees, benefits are equal to one times your annual County paid salary or a minimum of $25,000.
- Benefit is paid to your specified beneficiary in the event of your death.
- You are encouraged to review your life insurance policy for other features of this benefit.

Other Great Benefits & Incentives

✓CHC On-site Blood Draw/Health Assessment -100% employer paid with a paid day off work incentive for your participation

✓Wellness Incentive Program - employer contribution to your HSA for your participation

✓***POINTS*** Program - paid day off work incentive for your completion of the program

✓Employee Assistance Program (EAP) – 100% Employer Paid

✓Flexible Spending Account (FSA) – *certain limitations apply*

✓Weight Watchers Weight Loss Program – 100% Employer Paid

https://www.co.warren.oh.us/omb/HealthWellness/Default.aspx

Employee Assistance Program (EAP)

An EAP is designed to help you and your and your family deal with life's difficulties. Tri-Health is the Administrator of Warren County's EAP. This benefit includes:

- Cost Free – Allows up to 6 face-to-face counseling sessions per issue with a licensed social worker or therapist.

- **Completely confidential!**

- If more than 6 sessions are needed, Tri-Health will assist with the referral and transition to the behavioral health services provided under the health plan.

Flexible Spending Account (FSA)

- FSA's are administrated by ***Chard-Snyder***.
- Flexible Spending Accounts allow you to voluntarily convert part of your compensation into tax-free benefits to pay for eligible health care expenses. Warren County permits you to designate up to $2,850 annually under this benefit.
- If you contribute to an HSA or your spouse contributes to an HSA, you are ***not*** eligible to have a **Full FSA**. However,
- If you have an HSA, you are eligible to participate in a ***Limited FSA*** which allows pre-tax dollars to pay for out-of-pocket **dental** and **vision expenses only**. Warren County permits you to voluntarily designate up to $2,850 of your compensation on an annual basis.
- **Dependent Care** Flexible Spending Accounts use pre-tax dollars to pay for eligible out-of-pocket dependent daycare expenses. The maximum for this benefit is set annually by the IRS.

Note: *An FSA, Limited FSA, and Dependent Care FSA are* ***use-it or lose-it benefits****. You are encouraged to make a conservative estimate on the amount of money you allocate to this benefit.*

Be an Informed Healthcare Consumer

- Choose an in-network provider.
- Make sure you understand your benefit plan.
- Ask Questions! Many people pay too much money for too much care or the wrong type of care because they don't ask questions.
- Discuss various treatments and their cost with your physician to help you select the best treatment.
- Request necessary lab testing and x-rays be done at your physician's office instead of at the hospital where costs are much higher.
- Check your medical statements to make sure you were billed for the services you received.

Ways to Save Money on Your Prescription Cost

- Utilize generic medication! Generic drugs are the FDA approved alternatives to your brand name medication. You can expect the same safety and effect as the name brand drug, but at a lower cost to you.

- Shop pharmacies to get the lowest price. Check out special programs that may be offered.

- Ask your doctor for samples on newly prescribed medication to ensure effectiveness and tolerance before you fill.

- Discuss pill splitting with your doctor and pharmacist.

- Consider mail service which offers convenience of a 90 day supply, and may also present a savings opportunity.

Contact List

- United Healthcare – (877) 468-0980 **www.myuhc.com**
- OptumRx – (888) 311-3763 **www.optumrx.com**
- Dental Care Plus (DCP) – (513) 554-1100 **www.dentalcareplus.com**
- EyeMed – (866) 723-0513 **www.eyemed.com**
- Horan Associates – (800) 544-8306
- Tri-Health – (513) 891-1627 (800) 642-9794 **trihealtheap.com**
- 1st National Bank (HSA) - (513) 932-3221 **www.bankwith1st.com**
- Chard Snyder (FSA and HRA) – (513) 459-9997 or (800) 982-7715
- Weight Watchers - **https://www.weightwatchers.com/us/wwhs**
- OMB Benefits Division – (513) 695-1324

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0245 *Adopted Date* February 20, 2024

ACKNOWLEDGING THE APPOINTMENT JULIE SEITZ TO THE COUNTYWIDE 9-1-1 PROGRAM REVIEW COMMITTEE

WHEREAS, pursuant to Resolution #24-0140, adopted January 23, 2024, this Board re-established the Countywide 9-1-1 Program Review Committee (FKA Countywide 9-1-1 Planning Committee); and

WHEREAS, pursuant to O.R.C. Section 128.06, a member of the Board of Trustees of the most populous township in the county shall serve as a member on the committee; and

WHEREAS, pursuant to Deerfield Township Resolution #2024-5, the Deerfield Township Trustees appointed Julie Seitz as their representative to said committee.

NOW THEREFORE BE IT RESOLVED, to acknowledge the appointment of Julie Seitz, Deerfield Township Trustee, to the Countywide 9-1-1 Program Review Committee for an indefinite term.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Telecom (file)
Appointments file
Appointees
L. Lander

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0246 *Adopted Date* February 20, 2024

CANCELLING REGULARLY SCHEDULED COMMISSIONERS' MEETING OF THURSDAY, FEBRUARY 22, 2024

BE IT RESOLVED, to cancel the regularly scheduled Commissioners' Meeting of Thursday, February 22, 2024.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

/kp

cc: Auditor ✓
Commissioners' file
Press ✓

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0247 *Adopted Date* February 20, 2024

APPROVING ADDENDA TO AGREEMENT WITH REFLECTIONS GROUP HOME LLC RELATIVE TO HOME PLACEMENT AND RELATED SERVICES ON BEHALF OF WARREN COUNTY CHILDREN SERVICES

BE IT RESOLVED, to approve and authorize the Warren County Board of Commissioners to enter into the addenda to agreement with Reflections Group Home LLC relative to home placement and related services for calendar year 2023-2024, on behalf of Children Services as attached hereto and made a part hereof:

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: c/a – Reflections Group Home LLC
Children Services (file)

Ohio Department of Job and Family Services

AGREEMENT FOR TITLE IV-E AGENCIES AND PROVIDERS FOR THE PROVISION OF CHILD PLACEMENT

ADDENDA TO AGREEMENT

The following addendum sets forth the terms and conditions between the parties for services for children involved with the agency named below:

This Agreement is between Warren County Children Services, A Title IV-E Agency, hereinafter "Agency," whose address is:

Warren County Children Services
416 S East St
Lebanon, OH 45036

And Reflections Group Home LLC hereinafter "Provider," whose address is:

Reflections Group Home LLC
5056 Galileo Ave
Dayton, OH 45426

Collectively the "Parties".

Contract ID: 19329126 Originally Dated: 06/01/2023 to 05/31/2024

Ohio Department of Job and Family Services

AGREEMENT FOR TITLE IV-E AGENCIES AND PROVIDERS FOR THE PROVISION OF CHILD PLACEMENT

Addenda Number 1:

Addenda Reason: Other
Addenda Begin Date: 12/01/2023
Addenda End Date:
Increased Amount:
Article Name:

Addenda Reason Narrative:
Need to add the rate of $360 to the IV-E rate sheet for a specified child.

SIGNATURE OF THE PARTIES

Provider: Reflections Group Home LLC

Print Name & Title	Signature	Date
Kristin Draper Administrator		1/26/24

Agency: Warren County Children Services

Print Name & Title	Signature	Date
Shawna Jones, Director	Shawna Jones	2-14-24

Additional Signatures

Print Name & Title	Signature	Date
David G. Young president		2-20-24

APPROVED AS TO FORM
Kathryn M. Horvath
Asst. Prosecuting Attorney

Title IV-E Schedule A Rate Information

Title IV-E Schedule A Rate Information
Agency: Warren County Children Services
Provider / ID: Reflections Group Home LLC / 27982920

Run Date: 01/23/2024
Contract Period: 06/01/2023 - 05/31/2024

Service Description	Service ID	Person	Person ID	Maintenance Per Diem	Administration Per Diem	Case Management Per Diem	Transportation / Administration Per Diem	Transporation / Maintenance Per Diem	Other Direct Services Per Diem	Behavioral Healthcare Per Diem	Other Per Diem Cost	Total Per Diem Cost	Cost Begin Date	Cost End Date
Group Home 1 (20958)	7640963			$211.00	$24.00							$235.00	06/01/2023	05/31/2024
Group Home 2 (20974)	7655463			$211.00	$24.00							$235.00	06/01/2023	05/31/2024
Group Home 2 (20974)	7655463			$327.00	$33.00							$360.00	12/01/2023	05/31/2024
Group Home 3 (20986)	7658764			$211.00	$24.00							$235.00	06/01/2023	05/31/2024

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0248 *Adopted Date* February 20, 2024

AUTHORIZING THE BOARD OF COMMISSIONERS TO SIGN IV-D SERVICE CONTRACT BETWEEN THE WARREN COUNTY DOMESTIC RELATIONS DIVISION AND THE WARREN COUNTY CHILD SUPPORT ENFORCEMENT AGENCY

BE IT RESOLVED, to approve and authorize the Board of Commissioners to sign IV-D Service contract between the Warren County Domestic Relations Division and the Warren County Child Support Enforcement Agency; as attached hereto and made a part hereof.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: c/a—Domestic Relations Court
c/a—CSEA
Domestic Relations Court (file)
CSEA (file)

Warren County CSEA
500 Justice Drive
P O Box 440
Lebanon, Ohio 45036

Ohio Department of Job and Family Services
Office of Child Support
Fiscal Administration, Contract Unit
P.O. Box 183203
Columbus, Ohio 43218-3203

Date: 2/1/2024

Ohio Department of Job and Family Services
IV-D CONTRACT COVER LETTER

The IV-D Contract is between the Warren County Child Support Enforcement Agency (CSEA) and the:

- ☐ Clerk of Court
- ☐ County Prosecutor
- ☐ Court of Common Pleas, Juvenile Division
- ☒ Court of Common Pleas, Domestic Relations Division
- ☐ Sheriff
- ☐ Other Legal Services Provider
- ☐ Other: <describe the IV-D contract>

This IV-D Contract is for the following services:

- ☐ Clerk of Court filing services
- ☐ Legal Services
- ☒ Magistrate Services
- ☐ Service of Process
- ☐ Security
- ☐ Other: <describe the IV-D contract>

The unit rate is $73.39per hour (from paragraph 4A of the JFS 07018).

The IV-D Contract effective dates are: 1/1/24 to 12/31/24. The IV-D Contract Amendment, if applicable, effective dates are: <beginning date> to <ending date>.

A copy of the following forms are being submitted to the Office of Child Support (OCS) in accordance with Ohio Administrative Code (OAC) rule 5101:12-1-80.2 (please check the type of IV-D contract that applies and check each form that you have attached):

☒ IV-D Contract with Governmental Entity
- ☒ JFS 01772 " IV-D Contract Cover Letter"
- ☒ JFS 07018 "IV-D Contract" and attached document that describes the performance standards
- ☒ JFS 07020 "Governmental Contractor IV-D Contract Budget"
- ☒ Commissioners' resolution or minutes
- ☒ JFS 07016 "IV-D Contract Security Addendum"
- ☒ Appropriate summary page of the county cost allocation plan, if applicable
- ☐ Verification from sheriff that the sheriff charges other agencies service of process fees, if applicable and in accordance with OAC rule 5101:12-1-60

☐ IV-D Contract Amendment with Governmental Entity
- ☐ JFS 01772 "IV-D Contract Cover Letter"
- ☐ JFS 07037 "IV-D Contract Amendment" and attached document that describes the amended performance standards, if applicable
- ☐ JFS 07020 "Governmental Contractor IV-D Contract Budget"
- ☐ Commissioners' resolution or minutes

☐ IV-D Contract with Private Entity
- ☐ JFS 01772 "IV-D Contract Cover Letter"
- ☐ JFS 07018 "IV-D Contract"
- ☐ JFS 07015 "Certification of Compliance with Competitive Sealed Bid Requirements"
- ☐ Commissioners' resolution or minutes
- ☐ JFS 07016 "IV-D Contract Security Addendum"

☐ IV-D Contract Amendment with Private Entity
- ☐ JFS 01772 "IV-D Contract Cover Letter"
- ☐ JFS 07037 "IV-D Contract Amendment"
- ☐ Commissioners' resolution or minutes

The CSEA hereby certifies that:
- ☒ All required documents have been reviewed
- ☒ All required documents are included
- ☒ All mathematical calculations are correct
- ☒ This submission is timely
- ☒ All required dated signatures have been obtained
- ☐ Other: <describe the additional determinations>

02-13-24

Signature

Printed Name: Thomas Howard, Director
Telephone Number: 513-695-1668

Ohio Department of Job and Family Services

IV-D CONTRACT

Pursuant to Title IV-D of the Social Security Act, Parts 302, 303, and 304 of Title 45 of the Code of Federal Regulations (CFR); sections 3125.13 to 3125.17 of the Ohio Revised Code; and rules 5101:12-1-80 to 5101:12-1-80.4 of the Ohio Administrative Code (hereafter "IV-D Contract rules"), the Warren County Child Support Enforcement Agency (hereafter "CSEA") enters into this IV-D Contract with Warren County Domestic Relations Court (hereafter "Contractor") to purchase services for the effective administration of the support enforcement program.

The CSEA and the Contractor certify that all IV-D Contract activities shall be performed in compliance with Title IV-D of the Social Security Act, 45 CFR Parts 302, 303, and 304, and the rules in Division 5101:12 of the Administrative Code.

Unless otherwise specified, the terms of this IV-D Contract apply to both governmental contractors and private contractors.

The IV-D Contract consists of this document and all attached forms or documents that are incorporated and deemed to be a part of the IV-D Contract as if fully written herein. Nothing in this IV-D Contract shall be construed contrary to state or federal laws and regulations.

IV-D Contract Terms:

1. **IV-D Contract Period:** The IV-D Contract is effective from 1/1/24 through 12/31/24, unless terminated earlier in accordance with the terms listed in paragraph 23 of this IV-D Contract. The IV-D Contract period shall not exceed twelve (12) months. The CSEA and contractor may agree upon a IV-D Contract period that is less than twelve (12) months.

2. **Unit of Service:** Subject to the terms and conditions set forth in this IV-D Contract, the CSEA agrees to purchase and the Contractor agrees to provide the following Unit of Service for a IV-D case: An hourly rate for Magistrate services to: Conduct hearings; Prepare and review Magistrate reports; conduct status review for all eligible IV-D cases; including but not limited to establishment of paternity; establishment of support; enforcement of support and related orders.

   The CSEA and the Contractor certify that all units of service are eligible for federal financial participation (FFP) reimbursement in accordance with rules 5101:12-1-60 and 5101:12-1-60.1 of the Ohio Administrative Code, the IV-D Contract rules, and 2 CFR, Subtitle A, Chapter II, Part 225 (Circular A-87 of the Federal Office of Management and Budget).

3. **Optional Purchase of Non-CSEA Initiated Activities:** In a IV-D Contract with a court for magistrate services, the CSEA may elect to purchase non-CSEA initiated activities in addition to CSEA initiated activities. If the CSEA elects to purchase non-CSEA initiated activities in addition to CSEA initiated activities, the CSEA and the court shall signify the decision by placing their initials on the lines below.

Initials of Authorized CSEA Representative	Initials of Authorized Court Representative

4. **IV-D Contract Costs:**

   4A. Unit Rate: The Unit Rate for this IV-D Contract is $73.39 per Unit of Service as determined by:
   - The calculation listed in the JFS 07020 (Governmental Contractor IV-D Contract Budget) for a IV-D Contract with a governmental entity; or
   - The procurement process for a IV-D Contract with a private entity.

   4B. Total IV-D Contract Cost: The Total IV-D Contract Cost is $19,080.50

5. **Availability of Funds:** The CSEA certifies that it has adequate funds to meet its obligations under this IV-D Contract, that it intends to maintain this IV-D Contract for the full period set forth herein, that it believes that it will have sufficient funds to enable it to make all payments due hereunder during such period, and that it will use its best effort to obtain the appropriation of any necessary funds during the term of this IV-D Contract.

   5A. Payments for all services provided in accordance with the provisions of this IV-D Contract are contingent upon the availability of the non-federal share and FFP reimbursement, as follows:

	Amount	Source
Non-Federal Share	$6,487.37	Local Sources
FFP Reimbursement	$12,593.13	
Total IV-D Contract Cost	$19,080.50	

5B. The CSEA certifies that the non-federal share is not provided from any source that is prohibited by state or federal law.

6. **Performance Standards:** The performance standards shall be based upon the requirements in 45 CFR Part 303. The performance standards are attached to this IV-D Contract in a separate document with a label at the top of the first page that reads, "Performance Standards."

7. **Access to the Public:** The CSEA and the Contractor agree to make all reasonable efforts to allow public access by providing services between the hours of 8:00 and 4:30 on the following days Monday - Friday with the exception of the following days: New Years Day, Martin Luther King Day, President's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve 1/2 day, Christmas Day.

8. **Amendments to and Modifications of the IV-D Contract:** The Office of Child Support (OCS) will review all IV-D Contract amendments or modifications and determine whether the amendments or modifications are acceptable for purposes of FFP reimbursement. Language in this IV-D Contract shall not be modified, deleted, struck out, or added, except for the following:

   - **Amendments:** The CSEA or Contractor may amend any information in the insertable fields in the first paragraph of the IV-D Contract or IV-D Contract Terms 1 through 7, provided that both the CSEA and Contractor agree to the amendments, the CSEA submits the amendments to OCS on the JFS 07037 (IV-D Contract Amendment), and OCS accepts the JFS 07037; or

   - **Modifications:** The CSEA or Contractor may modify the language in this IV-D Contract, provided that both the CSEA and the Contractor agree to the modifications, the CSEA submits the proposed modifications to OCS, and OCS accepts the modifications. If the CSEA or Contractor modifies the language in this IV-D Contract without the agreement of both parties to the IV-D Contract and acceptance from OCS, the modified IV-D Contract will have no force or effect of law.

9. **Billing Requirements:** When the Contractor is a private entity, the Contractor shall ensure that the JFS 07035 (IV-D Contract Invoice) is submitted to the CSEA no later than thirty (30) days after the last day of the month in which services were provided.

   When the Contractor is a governmental entity, the Contractor shall ensure that the JFS 07034 (Governmental Contactor Monthly Expense Report) and the JFS 07035 are submitted to the CSEA no later than thirty (30) days after the last day of the month in which services were provided. If the Contractor neglects or refuses to submit the JFS 07034 or JFS 07035 to the CSEA for payment within the appropriate time frame, the CSEA reserves the right to refuse payment.

   If the Contractor neglects or refuses to submit the JFS 07035 to the CSEA for payment within the appropriate time frame, the CSEA reserves the right to refuse payment.

10. **Expensed Equipment:** Equipment that has been included in the unit rate on the JFS 07020 and expensed rather than depreciated during the IV-D Contract period shall be transferred to the CSEA or the appropriate residual value shall be paid to the CSEA when the equipment is no longer needed to carry out the work under this IV-D Contract or a succeeding IV-D contract.

11. **Monitoring and Evaluation:** The CSEA and the Contractor shall monitor and evaluate the extent to which services described in the IV-D Contract are being performed. The CSEA shall evaluate the performance of the Contractor on the JFS 02151 (IV-D Contract Evaluation) and provide a copy of the completed JFS 02151 to the Contractor.

12. **Recordkeeping:** The Contractor shall maintain accounting procedures and practices that sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this IV-D Contract. All books, records, payroll, and documents related to this IV-D Contract that are in the possession of the Contractor or of a third party performing work related to this IV-D Contract shall be maintained and preserved by the Contractor for a period of three years after final payment, unless otherwise directed by the CSEA. Such records shall be subject at all reasonable times for inspection, review, or audit by duly authorized federal, state, and CSEA personnel or their designees. If an audit, litigation, or other action involving the records is started before the end of the three-year period, the records must be retained until all issues arising from the action are resolved or until the end of the three-year period, whichever is later.

13. **Responsibility for Review or Audit Findings and Recommendations:** The Contractor agrees to accept responsibility for replying to and complying with any review or audit findings and recommendations by an authorized state or federal review or audit that are directly related to the provisions of this IV-D Contract.

14. **Indemnity:** When the Contractor is a private entity, the Contractor shall certify that it will at all times during the existence of this IV-D Contract indemnify and hold harmless the CSEA, the Ohio Department of Job and Family Services, and the Board of County Commissioners or county administrator in the same county as the CSEA against any and all liability, loss, damage, and/or related expenses incurred through the provision of services under this IV-D Contract.

15. **Insurance:** When the Contractor is a private entity, the Contractor shall contract for such insurance as is reasonably necessary to adequately secure the persons and estates of eligible individuals against reasonable, foreseeable torts that could cause injury or death.

16. **Finding for Recovery:** The Contractor certifies that the Contractor is not subject to a finding for recovery or it has taken the appropriate remedial steps required under section 9.24 of the Ohio Revised Code or it otherwise qualifies to contract with the State of Ohio under section 9.24 of the Ohio Revised Code.

17. **Licenses:** The Contractor certifies that all approvals, licenses, or other qualifications necessary to conduct business or, if applicable, practice law in Ohio have been obtained and are operative. If at any time during the IV-D Contract period the Contractor becomes disqualified or suspended from conducting business or, if applicable, practicing law in Ohio, the Contractor must immediately notify the CSEA of the disqualification or suspension and the Contractor will immediately cease performance of any obligations under this IV-D Contract.

18. **Independent Capacity for the Contractor:** The Contractor and its agents, employees, and subcontractors will act in performance of this IV-D Contract in an independent capacity and not as officers or employees or agents of the State of Ohio or the CSEA.

19. **Confidentiality:** The Contractor agrees that information regarding an individual shall only be used for purposes related to the IV-D program, in accordance with rules 5101:12-1-20 to 5101:12-1-20.2 of the Ohio Administrative Code. Disclosure of information for any other purpose is prohibited.

20. **Americans with Disabilities Act (ADA) Compliance:** The Contractor certifies that it is in full compliance with all statutes and regulations pertaining to the ADA of 1990 and with section 504 of the Rehabilitation Act of 1973.

21. **Civil Rights:** The Contractor certifies compliance with rule 5101:9-2-01 of the Ohio Administrative Code.

22. **Equal Employment Opportunity:** In carrying out this IV-D Contract, the Contractor shall not discriminate against any employee or applicant for employment because of race, religion, national origin, ancestry, color, sex, age, disability, or veteran status. The Contractor shall ensure that applicants are hired and that employees are treated during employment without regard to their race, religion, national origin, ancestry, color, sex, age, disability, or veteran status. Such action shall include but not be limited to the following: employment, upgrading, demotion, transfer, recruitment, recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship.

23. **Termination:** This IV-D Contract may be terminated:

23A. By mutual agreement at any time after the date on which the two parties reach their decision.

23B. If FFP reimbursement or the non-federal share designated for the purchase of services under this IV-D Contract is not available to the CSEA in an amount adequate to support the IV-D Contract as determined by the CSEA. When termination of the IV-D Contract occurs under this paragraph, the termination date is the date upon which the FFP reimbursement or non-federal share is no longer available; however, the CSEA may determine a later termination date. The CSEA shall provide the Contractor written notice of the termination but is not required to provide written notice in advance of the termination. Reimbursement to the Contractor will cease on the date of termination of the IV-D Contract.

23C. If the CSEA has discovered any illegal conduct on the part of the Contractor, immediately upon delivery of written notice to the Contractor by the CSEA.

23D. If the Contractor does not faithfully and promptly perform its responsibilities and obligations under this IV-D Contract as determined by the CSEA. If the CSEA elects to terminate the IV-D Contract, the CSEA shall provide the Contractor with written notice thirty days in advance of the termination date.

23E. If the CSEA does not faithfully and promptly perform its responsibilities and obligations under this IV-D Contract, as determined by the Contractor. If the Contractor elects to terminate the IV-D Contract, the Contractor shall provide the CSEA with written notice thirty days in advance of the termination date.

23F. If the IV-D Contract is for legal services and the Contractor becomes disqualified or suspended from conducting business or practicing law in Ohio, all obligations under this IV-D Contract shall immediately terminate and the Contractor shall immediately notify the CSEA and cease the performance of any obligations under this IV-D Contract.

When the IV-D Contract terminates, the Contractor shall be entitled to compensation upon submission of the appropriate form(s), as described in paragraph 9, for the work performed prior to:

- The date on which the parties reached their decision, in accordance with paragraph 23A;
- The receipt of the written notice of termination, in accordance with paragraphs 23B through 23E; or
- The Contractor being disqualified or suspended from conducting business or practicing law, in accordance with paragraph 23F.

The CSEA shall calculate the compensation based on the Total IV-D Contract Cost less any funds previously paid by or on behalf of the CSEA. The Contractor shall not exceed the Total IV-D Contract Cost. The CSEA shall not be liable for any further claims.

IV-D Contract Signatures:

Signature of CSEA's Representative	Printed Name of CSEA's Representative
	Thomas Howard, Director
Date of Signature 2-15-24	

Signature of Contractor's Representative	Printed Name of Contractor's Representative
	Jeff Kirby, Judge
Date of Signature 2/12/24	Printed Street Address of Contractor 500 Justice Drive
Printed Title of Contractor's Representative Judge	Printed City, State, and Zip Code of Contractor Lebanon, Ohio 45036

Signature of County Commissioner or Representative	Date of Signature
*	2-20-24
Signature of County Commissioner or Representative *	Date of Signature 2-20-24
Signature of County Commissioner or Representative	Date of Signature
Signature of Prosecutor, if required by County Commissioners	Date of Signature 2/8/24

Prosecuting Attorney
David P. Fornshell

CHILD SUPPORT ENFORCEMENT AGENCY
WARREN COUNTY, OHIO

Director, CSEA
Thomas E.A. Howard

500 Justice Drive ▪ Lebanon, Ohio 45036
Phone: (513) 695-1580
Fax: (513) 695-2969
http://www.co.warren.oh.us/wcchildsupport

Re: **Performance Standards**

- Court shall provide a Magistrate for agreed upon dockets.
- Provided Magistrate shall be prepared to adjudicate all child support cases brought before him/her on said dockets. All cases on the dockets must have an active IV-D application on file with the Warren County Child Support Enforcement Agency. Further, any litigated issues must be IV-D reimbursable.
- Court shall provide the Magistrate with appropriate space and materials to properly adjudicate cases on said dockets.
- Magistrate shall expeditiously adjudicate all cases on said dockets.

Ohio Department of Job and Family Services

GOVERNMENTAL CONTRACTOR IV-D CONTRACT BUDGET

Summary Sheet		
County:	Warren County	
Governmental Contractor:	Domestic Relations Court	
Type of IV-D Contract:	Magistrate Services	
I. Staff		Estimated Amount
	A. Salaries	$56,700.00
	B. Payroll Related Expenses	$29,863.83
	Total Staff Costs	$86,563.83
II. Operations		
	A. Travel and Short Term Training	$1,000.00
	B. Consumable Supplies	$0.00
	C. Occupancy Costs	$0.00
	D. Indirect Costs	$0.00
	E. Contract and Professional Services	$500.00
	F. Miscellaneous	$0.00
	Total Operations Costs	$1,500.00
III. Equipment		
	A. Equipment Subject to Depreciation	$0.00
	B. Equipment Purchases	$0.00
	C. Leased and Rented Equipment	$0.00
	Total Equipment Costs	$0.00
	Sub-Total of All Costs	$88,063.83
	IV. MINUS Fees Collected by the Contractor	$0.00
	Total Expenses	$88,063.83

I.A. Salaries

I.A.1. Principal Staff

Position Title	Total Annual Hours Paid by County	Annual Hours Worked In Contracted Office	Annual Salary	% of Salary Applied to Budget	Salary Applied to Budget
Magistrate 1	1200	1200	$56,700.00	100.00%	$56,700.00

Notes:

I.A. Salaries

I.A.2. Support Staff

Position Title	Total Annual Hours Paid by County	Total Hours Spent Assisting Principal Staff	Annual Salary	% of Salary Applied to Budget	Salary Applied to Budget

I.A.3. Unassociated Staff

Position Title	

Total Salaries Applied to this Contract $56,700.00

I.B. Payroll Related Expenses

Type	Percentage	Salary	Amount Applied to Budget
OPERS or Social Security	14.00%	$56,700.00	$7,938.00
Workers' Compensation/Unemployment Insurance		$56,700.00	$0.00
Retirement Expense/Medicare	1.45%	$56,700.00	$822.15
Hospitalization Insurance Premium			$20,971.68
Other Life Insurance			$132.00
Other			
Other			
Other			
Other			
Other			
Total Payroll Related Expenses			$29,863.83

Notes:

II.A. Travel and Short Term Training

Type	Mileage rate	Miles	Amount	Prorate %	Amount Applied to Budget
			Total mileage		
Mileage Reimbursement			$0.00		
Short Term Training			$1,000.00	100.00%	$1,000.00
Other					
Other					
Other					
Total Travel and Short Term Training					$1,000.00

Notes:
To subscribe to the Key Partner Membership, to attend any trainings or conferences such as OCDA Spring Conference, OCDA Fall Conference or the OCDA Partner Conference

II.B. Consumable Supplies

Type	Amount	Prorate %	Amount Applied to Budget
Office Supplies			
Cleaning Supplies			
Other			
Other			
Other			
Other			
Other			
Total Consumable Supplies			$0.00

Notes:

II.C. Occupancy Costs

	Amount	Prorate %	Amount Applied to Budget
Rental at per square foot:	$0.00		
or			
Usage allowance/depreciation at % rate of original acquisition cost by Program Square Footage Percentage (Program Square Footage ÷ Provider Square Footage)			
Maintenance and Repairs			
Utilities (if not included in rent)			
Heat and Light			
Telephone			
Water			
Other:			
Other:			
Other:			
Total Occupancy Costs			$0.00

Notes:

II.D. Indirect Costs

Category	CAP Amount	Prorate %	Amount Applied to Budget
Total Indirect Costs			$0.00

Notes:

II.E. Contract & Professional Services

Type	Amount	Prorate %	Amount Applied to Budget
Transcripts	$500.00	100.00%	$500.00
Total Contract and Professional Services Costs			$500.00

Notes:

II.F. Miscellaneous

Description	Amount	Prorate %	Amount Applied to Budget
Total Miscellaneous Costs			$0.00

Notes:

III.A. Equipment Subject to Depreciation

Equipment to be Depreciated	New or Used	Purchase Date	Quantity	Total Actual Cost per Item	Salvage Value per Item	Total Amount to be Depreciated	Useful Life	Prorate %	Chargeable Amount of Depreciation
Total Equipment Depreciation Charges									$0.00

Notes:

III.B. Equipment Purchases

Item	Amount	Prorate %	Quantity	Amount Applied to Budget
Total Small Equipment Purchases				$0.00

Notes:

III.C. Lease and Rental Equipment

Item	Model and Year	Amount	Prorate %	Quantity	Amount Applied to Budget
Total Lease and Rental Equipment					$0.00

Notes:

BUDGET COMPUTATION WORKSHEET

Is this a IV-D Contract with a court for magistrate services in which a IV-D multiplier was used?

Select 1 or 2 ▶ 1

1 - no
2 - yes

Carried over from Page 1 ▼

$88,063.83	÷	1,200	=	$73.39
Total Expenses	Divided by	Total Operating Units Produced by Principal Staff	Equals	Unit Rate

$73.39	X	260	=	$19,080.50
Unit Rate	Multiplied by	Total Units of Service Purchased	Equals	100% Contract Value

Ohio Department of Job and Family Services

IV-D CONTRACT SECURITY ADDENDUM

By signing this form, the contractor agrees to comply with all of the terms and conditions described herein.

I. Ohio Department of Taxation Information

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

All Ohio Department of Taxation, taxpayer information concerning the residential address and income of taxpayers received by the contractor is needed for the purpose of and will be used only to the extent necessary in, locating obligors, or establishing, enforcing and collecting child support obligations pursuant to Part D, Title IV of the Social Security Act. None of the information so obtained will be disclosed except for official purposes as described in section 3125.43 of the Revised Code or in compliance with a court order.

II Federal Parent Locator Service Information (FPLS)

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

All information received by the contractor from FPLS is needed for the purpose of and will be used only to the extent necessary in, establishing and collecting child support obligations pursuant to Part D, Title IV of the Social Security Act. obligations or pursuant to a request in connection with a parental kidnapping or child custody case as described in federal regulations at 45 CFR 303.15 and 303.69. This information shall be treated as confidential.

III. Department of Job and Family Services, Office of Unemployment Compensation Information

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

All information and records received from the Ohio Department of Job and Family Services, Office of Unemployment Compensation shall be used only for the purposes of establishing and collecting child support obligations from and locating individuals owing such obligations. The contractor maintains security safeguards for location, wage, and benefit information.

IV. Internal Revenue Service (IRS) Information

A. Performance

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by officers or employees with the following requirements:

(1) All work will be performed under the supervision of the contractor.

(2) The contractor and the contractor's officers or employees to be authorized access to federal tax information (FTI) must meet background check requirements defined in IRS Publication 1075. The contractor will maintain a list of officers or employees authorized access to FTI. Such list will be provided to the agency and, upon request, to the IRS.

(3) FTI in hardcopy or electronic format shall be used only for the purpose of carrying out the provisions of this contract. FTI in any format shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Inspection or disclosure of FTI to anyone other than the contractor or the contractor's officers or employees authorized is prohibited.

(4) FTI will be accounted for upon receipt and properly stored before, during, and after processing. In addition, any related output and products require the same level of protection as required for the source material.

(5) The contractor will certify that FTI processed during the performance of this contract will be completely purged from all physical and electronic data storage with no output to be retained by the contractor at the time

the work is completed. If immediate purging of physical and electronic data storage is not possible, the contractor will certify that any FTI in physical or electronic storage will remain safeguarded to prevent unauthorized disclosures.

(6) Any spoilage or any intermediate hard copy printout that may result during the processing of FTI will be given to the agency. When this is not possible, the contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts and will provide the agency with a statement containing the date of destruction, description of material destroyed, and the destruction method.

(7) All computer systems receiving, processing, storing, or transmitting FTI must meet the requirements in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to FTI.

(8) No work involving FTI furnished under this contract will be subcontracted without the prior written approval of the IRS.

(9) Contractor will ensure that the terms of the FTI safeguards described herein are included, without modification, in any approved subcontract for work involving FTI.

(10) To the extent the terms, provisions, duties, requirements, and obligations of this contract apply to performing services with FTI, the contractor shall assume toward the subcontractor all obligations, duties and responsibilities that the agency under this contract assumes toward the contractor, and the subcontractor shall assume toward the contractor all the same obligations, duties and responsibilities which the contractor assumes toward the agency under this contract.

(11) In addition to the subcontractor's obligation and duties under an approved subcontract, the terms and conditions of this contract apply to the subcontractor, and the subcontractor is bound and obligated to the contractor hereunder by the same terms and conditions by which the contractor is bound and obligated to the agency under this contract.

(12) For purposes of this contact, the term "contractor" includes any officer or employee of the contractor with access to or who uses FTI, and the term "subcontractor" includes any officer or employee of the subcontractor with access to or who uses FTI.

(13) The agency will have the right to void the contract if the contractor fails to meet the terms of the FTI safeguards described herein.

B. Criminal and Civil Sanctions

(1) Each officer or employee of a contractor to whom FTI is or may be disclosed shall be notified in writing that FTI disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any FTI for a purpose not authorized herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as 5 years, or both, together with the costs of prosecution.

(2) Each officer or employee of a contractor to whom FTI is or may be accessible shall be notified in writing that FTI accessible to such officer or employee may be accessed only for a purpose and to the extent authorized herein, and that access/inspection of FTI without an officer need-to-know for a purpose not authorized herein constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution.

(3) Each officer or employee of a contractor to whom FTI is or may be disclosed shall be notified in writing that any such unauthorized access, inspection or disclosure of FTI may also result in an award of civil damages against the officer or employee in an amount equal to the sum of the greater of $1,000 for each unauthorized access, inspection, or disclosure, or the sum of actual damages sustained as a result of such unauthorized access, inspection, or disclosure, plus in the case of a willful unauthorized access, inspection, or disclosure or an unauthorized access/inspection or disclosure which is the result of gross negligence, punitive damages, plus the cost of the action. These penalties are prescribed by IRC sections 7213, 7213A and 7431 and set forth at 26 CFR 301.6103(n)-1.

(4) Additionally, it is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

(5) Granting a contractor access to FTI must be preceded by certifying that each individual understands the agency's security policy and procedures for safeguarding IRS information. Contractors must maintain their authorization to access FTI through annual recertification. The initial certification and recertification must be documented and placed in the agency's files for review. As part of the certification and at least annually afterwards, contractors must be advised of the provisions of IRCs 7431, 7213, and 7213A (see Exhibit 4, Sanctions for Unauthorized Disclosure, and Exhibit 5, Civil Damages for Unauthorized Disclosure). The training on the agency's security policy and procedures provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches. (See Section 10) For the initial certification and the annual recertifications, the contractor and each officer or employee must sign, either with ink or electronic signature, a confidentiality statement certifying their understanding of the security requirements.

C. Inspections

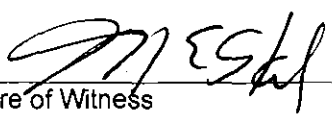
The IRS and the Agency, with 24-hour notice, shall have the right to send its inspectors into the offices and plants of the contractor to inspect facilities and operations performing any work with FTI under this contract for compliance with requirements defined in IRS Publication 1075. The IRS' right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology (IT) assets that access, store, process or transmit FTI. Based on the inspection, corrective actions may be required in cases where the contractor is found to be noncompliant with FTI safeguard requirements.

Warren County Domestic Relations Court
Printed Name of Contractor or Company

Signature of Contractor's Representative

2/12/24
Date

Jeff Kirby
Printed Name of Contractor's Representative



Signature of Witness

2/12/24
Date

Mary Ellen Steele
Printed Name of Witness

CSEA

CATEGORIES	2014 for use in 2016	2015 for use in 2017	2016 for use in 2018	2017 for use in 2019	2018 for use in 2020	2019 for use in 2021	2020 for use in 2022	2021 for use in 2023	2022 for use in 2024	Difference
Bldg Use	$ 9,540.00	$ 10,661.00	$ 10,637.00	$ 10,637.00	$ 18,953.00	$ 25,957.00	$ 27,915.00	$ 28,052.00	$ 28,052.00	$ -
Property Insurance	$ 2,142.00	$ 1,485.00	$ 1,572.00	$ 1,503.00	$ 476.00	$ 477.00	$ 492.00	$ 390.00	$ 473.00	$ 83.00
Insurance	$ 3,392.00	$ 1,988.00	$ 2,492.00	$ 2,017.00	$ 2,091.00	$ 1,995.00	$ 1,402.00	$ 2,674.00	$ 2,156.00	$ (518.00)
Commissioners	$ -	$ -							$ 1,817.00	$ 1,817.00
Bldg. Maintenance	$ 133,238.00	$ 143,509.00	$ 119,862.00	$ 126,371.00	$ 106,211.00	$ 103,719.00	$ 97,822.00	$ 78,759.00	$ 99,707.00	$ 20,948.00
OMB	$ 20,811.00	$ 20,822.00	$ 20,248.00	$ 24,419.00	$ 21,254.00	$ 22,915.00	$ 18,827.00	$ 19,188.00	$ 18,876.00	$ (312.00)
Vehicle Maintenance	$ -	$ -								$ -
Telecomm	$ 27,665.00	$ 42,067.00	$ 38,676.00	$ 43,771.00	$ 40,613.00	$ 50,797.00	$ 47,574.00	$ 41,865.00	$ 57,952.00	$ 16,087.00
Prosecutor	$ 11,423.00	$ 11,777.00	$ 12,425.00	$ 12,394.00	$ 12,576.00	$ 13,374.00	$ 13,992.00	$ 14,012.00	$ 14,841.00	$ 829.00
DP	$ 19,183.00	$ 15,594.00	$ 12,999.00	$ 39,599.00	$ 38,023.00	$ 44,173.00	$ 28,238.00	$ 23,391.00	$ 23,505.00	$ 114.00
Treasurer	$ 3,373.00	$ 3,307.00	$ 3,531.00	$ 4,089.00	$ 4,693.00	$ 4,800.00	$ 5,651.00	$ 4,770.00	$ 3,821.00	$ (949.00)
Auditor	$ 20,938.00	$ 17,083.00	$ 17,428.00	$ 19,167.00	$ 24,253.00	$ 21,413.00	$ 20,328.00	$ 20,262.00	$ 16,186.00	$ (4,076.00)
Total Allocated	$ 251,705.00	$ 268,293.00	$ 239,870.00	$ 283,967.00	$ 269,143.00	$ 289,620.00	$ 262,241.00	$ 233,363.00	$ 267,386.00	$ 34,023.00
Roll Forward	$ (3,277.00)	$ (942.00)	$ (11,835.00)	$ 15,674.00	$ 17,126.00	$ (6,641.00)	$ (6,902.00)	$ (56,257.00)	$ 5,145.00	$ 61,402.00
										$ -
Proposed Cost	$ 248,428.00	$ 267,351.00	$ 228,035.00	$ 299,641.00	$ 286,269.00	$ 282,979.00	$ 255,339.00	$ 177,106.00	$ 272,531.00	$ 95,425.00

2017 - Biggest Difference is in Telecomm. The Bd of DD has totally withdrawn from our system leaving fewer departments to spread the expenditures amongst.

2017 for use in 2019 - There was an increase within IT and the roll forward amount was a positive number verses in 2016 the roll forward was a negative number.

2020 for use in 2021 - decrease due to less employees, from 49 to 45

2021 for use in 2023 - decrease due to the Facilities allocation change from 2020

2023 for use in 2024 - increase in expenditures in Telecom and Facilities. Also, annual audit was in under Auditor - now under Commissioners - there is not an increase from this - just appears under the Commissioners line.

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0249 *Adopted Date* February 20, 2024

AUTHORIZING THE BOARD OF COMMISSIONERS TO SIGN IV-D SERVICE CONTRACT BETWEEN THE WARREN COUNTY JUVENILE DIVISION/ PROBATE COURT AND THE WARREN COUNTY CHILD SUPPORT ENFORCEMENT AGENCY

BE IT RESOLVED, to approve and authorize the Board of Commissioners to sign IV-D Service contract between the Warren County Juvenile Division/Probate Court and the Warren County Child Support Enforcement Agency; as attached hereto and made a part hereof.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: c/a – Juvenile Division/Probate Court
c/a – CSEA
Juvenile Court (file)
CSEA (file)

Warren County CSEA
500 Justice Drive
P O Box 440
Lebanon, Ohio 45036

Ohio Department of Job and Family Services
Office of Child Support
Fiscal Administration, Contract Unit
P.O. Box 183203
Columbus, Ohio 43218-3203

Date: 2/1/2024

Ohio Department of Job and Family Services
IV-D CONTRACT COVER LETTER

The IV-D Contract is between the Warren County Child Support Enforcement Agency (CSEA) and the:

- ☐ Clerk of Court
- ☐ County Prosecutor
- ☒ Court of Common Pleas, Juvenile Division
- ☐ Court of Common Pleas, Domestic Relations Division
- ☐ Sheriff
- ☐ Other Legal Services Provider
- ☐ Other: <describe the IV-D contract>

This IV-D Contract is for the following services:

- ☐ Clerk of Court filing services
- ☐ Legal Services
- ☒ Magistrate Services
- ☐ Service of Process
- ☐ Security
- ☐ Other: <describe the IV-D contract>

The unit rate is $72.69 per hour (from paragraph 4A of the JFS 07018).

The IV-D Contract effective dates are: 1/1/24 to 12/31/24. The IV-D Contract Amendment, if applicable, effective dates are: <beginning date> to <ending date>.

A copy of the following forms are being submitted to the Office of Child Support (OCS) in accordance with Ohio Administrative Code (OAC) rule 5101:12-1-80.2 (please check the type of IV-D contract that applies and check each form that you have attached):

☒ IV-D Contract with Governmental Entity
- ☒ JFS 01772 " IV-D Contract Cover Letter"
- ☒ JFS 07018 "IV-D Contract" and attached document that describes the performance standards
- ☒ JFS 07020 "Governmental Contractor IV-D Contract Budget"
- ☒ Commissioners' resolution or minutes
- ☒ JFS 07016 "IV-D Contract Security Addendum"
- ☒ Appropriate summary page of the county cost allocation plan, if applicable
- ☐ Verification from sheriff that the sheriff charges other agencies service of process fees, if applicable and in accordance with OAC rule 5101:12-1-60

☐ IV-D Contract Amendment with Governmental Entity
- ☐ JFS 01772 "IV-D Contract Cover Letter"
- ☐ JFS 07037 "IV-D Contract Amendment" and attached document that describes the amended performance standards, if applicable
- ☐ JFS 07020 "Governmental Contractor IV-D Contract Budget"
- ☐ Commissioners' resolution or minutes

- ☐ IV-D Contract with Private Entity
  - ☐ JFS 01772 "IV-D Contract Cover Letter"
  - ☐ JFS 07018 "IV-D Contract"
  - ☐ JFS 07015 "Certification of Compliance with Competitive Sealed Bid Requirements"
  - ☐ Commissioners' resolution or minutes
  - ☐ JFS 07016 "IV-D Contract Security Addendum"

- ☐ IV-D Contract Amendment with Private Entity
  - ☐ JFS 01772 "IV-D Contract Cover Letter"
  - ☐ JFS 07037 "IV-D Contract Amendment"
  - ☐ Commissioners' resolution or minutes

The CSEA hereby certifies that:

- ☒ All required documents have been reviewed
- ☒ All required documents are included
- ☒ All mathematical calculations are correct
- ☒ This submission is timely
- ☒ All required dated signatures have been obtained
- ☐ Other: <describe the additional determinations>

Signature

Printed Name: Thomas Howard
Telephone Number: 513-695-1668

Ohio Department of Job and Family Services

IV-D CONTRACT

Pursuant to Title IV-D of the Social Security Act, Parts 302, 303, and 304 of Title 45 of the Code of Federal Regulations (CFR); sections 3125.13 to 3125.17 of the Ohio Revised Code; and rules 5101:12-1-80 to 5101:12-1-80.4 of the Ohio Administrative Code (hereafter "IV-D Contract rules"), the Warren County Child Support Enforcement Agency (hereafter "CSEA") enters into this IV-D Contract with Warren County Juvenile Court (hereafter "Contractor") to purchase services for the effective administration of the support enforcement program.

The CSEA and the Contractor certify that all IV-D Contract activities shall be performed in compliance with Title IV-D of the Social Security Act, 45 CFR Parts 302, 303, and 304, and the rules in Division 5101:12 of the Administrative Code.

Unless otherwise specified, the terms of this IV-D Contract apply to both governmental contractors and private contractors.

The IV-D Contract consists of this document and all attached forms or documents that are incorporated and deemed to be a part of the IV-D Contract as if fully written herein. Nothing in this IV-D Contract shall be construed contrary to state or federal laws and regulations.

IV-D Contract Terms:

1. **IV-D Contract Period:** The IV-D Contract is effective from 1/1/24 through 12/31/24, unless terminated earlier in accordance with the terms listed in paragraph 23 of this IV-D Contract. The IV-D Contract period shall not exceed twelve (12) months. The CSEA and contractor may agree upon a IV-D Contract period that is less than twelve (12) months.

2. **Unit of Service:** Subject to the terms and conditions set forth in this IV-D Contract, the CSEA agrees to purchase and the Contractor agrees to provide the following Unit of Service for a IV-D case: An hourly rate for Magistrate services to: Conduct hearings; to prepare and review Magistrate reports; and to conduct status review for all eligible IV-D cases; including but not limited to establishment of paternity; establishment of support, enforcement of support and related orders.

   The CSEA and the Contractor certify that all units of service are eligible for federal financial participation (FFP) reimbursement in accordance with rules 5101:12-1-60 and 5101:12-1-60.1 of the Ohio Administrative Code, the IV-D Contract rules, and 2 CFR, Subtitle A, Chapter II, Part 225 (Circular A-87 of the Federal Office of Management and Budget).

3. **Optional Purchase of Non-CSEA Initiated Activities:** In a IV-D Contract with a court for magistrate services, the CSEA may elect to purchase non-CSEA initiated activities in addition to CSEA initiated activities. If the CSEA elects to purchase non-CSEA initiated activities in addition to CSEA initiated activities, the CSEA and the court shall signify the decision by placing their initials on the lines below.

Initials of Authorized CSEA Representative	Initials of Authorized Court Representative

4. **IV-D Contract Costs:**

   4A. Unit Rate: The Unit Rate for this IV-D Contract is $72.69 per Unit of Service as determined by:
   - The calculation listed in the JFS 07020 (Governmental Contractor IV-D Contract Budget) for a IV-D Contract with a governmental entity; or
   - The procurement process for a IV-D Contract with a private entity.

   4B. Total IV-D Contract Cost: The Total IV-D Contract Cost is $46,300.79

5. **Availability of Funds:** The CSEA certifies that it has adequate funds to meet its obligations under this IV-D Contract, that it intends to maintain this IV-D Contract for the full period set forth herein, that it believes that it will have sufficient funds to enable it to make all payments due hereunder during such period, and that it will use its best effort to obtain the appropriation of any necessary funds during the term of this IV-D Contract.

   5A. Payments for all services provided in accordance with the provisions of this IV-D Contract are contingent upon the availability of the non-federal share and FFP reimbursement, as follows:

	Amount	Source
Non-Federal Share	$15,742.27	Local Sources
FFP Reimbursement	$30,558.52	
Total IV-D Contract Cost	$46,300.79	

5B. The CSEA certifies that the non-federal share is not provided from any source that is prohibited by state or federal law.

6. **Performance Standards:** The performance standards shall be based upon the requirements in 45 CFR Part 303. The performance standards are attached to this IV-D Contract in a separate document with a label at the top of the first page that reads, "Performance Standards."

7. **Access to the Public:** The CSEA and the Contractor agree to make all reasonable efforts to allow public access by providing services between the hours of 8:00 and 4:30 on the following days Monday - Friday with the exception of the following days: New Years Day, Martin Lurther King Day, President's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve 1/2 Day, Christmas Day. .

8. **Amendments to and Modifications of the IV-D Contract:** The Office of Child Support (OCS) will review all IV-D Contract amendments or modifications and determine whether the amendments or modifications are acceptable for purposes of FFP reimbursement. Language in this IV-D Contract shall not be modified, deleted, struck out, or added, except for the following:

   - **Amendments:** The CSEA or Contractor may amend any information in the insertable fields in the first paragraph of the IV-D Contract or IV-D Contract Terms 1 through 7, provided that both the CSEA and Contractor agree to the amendments, the CSEA submits the amendments to OCS on the JFS 07037 (IV-D Contract Amendment), and OCS accepts the JFS 07037; or

   - **Modifications:** The CSEA or Contractor may modify the language in this IV-D Contract, provided that both the CSEA and the Contractor agree to the modifications, the CSEA submits the proposed modifications to OCS, and OCS accepts the modifications. If the CSEA or Contractor modifies the language in this IV-D Contract without the agreement of both parties to the IV-D Contract and acceptance from OCS, the modified IV-D Contract will have no force or effect of law.

9. **Billing Requirements:** When the Contractor is a private entity, the Contractor shall ensure that the JFS 07035 (IV-D Contract Invoice) is submitted to the CSEA no later than thirty (30) days after the last day of the month in which services were provided.

   When the Contractor is a governmental entity, the Contractor shall ensure that the JFS 07034 (Governmental Contactor Monthly Expense Report) and the JFS 07035 are submitted to the CSEA no later than thirty (30) days after the last day of the month in which services were provided. If the Contractor neglects or refuses to submit the JFS 07034 or JFS 07035 to the CSEA for payment within the appropriate time frame, the CSEA reserves the right to refuse payment.

   If the Contractor neglects or refuses to submit the JFS 07035 to the CSEA for payment within the appropriate time frame, the CSEA reserves the right to refuse payment.

10. **Expensed Equipment:** Equipment that has been included in the unit rate on the JFS 07020 and expensed rather than depreciated during the IV-D Contract period shall be transferred to the CSEA or the appropriate residual value shall be paid to the CSEA when the equipment is no longer needed to carry out the work under this IV-D Contract or a succeeding IV-D contract.

11. **Monitoring and Evaluation:** The CSEA and the Contractor shall monitor and evaluate the extent to which services described in the IV-D Contract are being performed. The CSEA shall evaluate the performance of the Contractor on the JFS 02151 (IV-D Contract Evaluation) and provide a copy of the completed JFS 02151 to the Contractor.

12. **Recordkeeping:** The Contractor shall maintain accounting procedures and practices that sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this IV-D Contract. All books, records, payroll, and documents related to this IV-D Contract that are in the possession of the Contractor or of a third party performing work related to this IV-D Contract shall be maintained and preserved by the Contractor for a period of three years after final payment, unless otherwise directed by the CSEA. Such records shall be subject at all reasonable times for inspection, review, or audit by duly authorized federal, state, and CSEA personnel or their designees. If an audit, litigation, or other action involving the records is started before the end of the three-year period, the records must be retained until all issues arising from the action are resolved or until the end of the three-year period, whichever is later.

13. **Responsibility for Review or Audit Findings and Recommendations:** The Contractor agrees to accept responsibility for replying to and complying with any review or audit findings and recommendations by an authorized state or federal review or audit that are directly related to the provisions of this IV-D Contract.

14. **Indemnity:** When the Contractor is a private entity, the Contractor shall certify that it will at all times during the existence of this IV-D Contract indemnify and hold harmless the CSEA, the Ohio Department of Job and Family Services, and the

Board of County Commissioners or county administrator in the same county as the CSEA against any and all liability, loss, damage, and/or related expenses incurred through the provision of services under this IV-D Contract.

15. **Insurance:** When the Contractor is a private entity, the Contractor shall contract for such insurance as is reasonably necessary to adequately secure the persons and estates of eligible individuals against reasonable, foreseeable torts that could cause injury or death.

16. **Finding for Recovery:** The Contractor certifies that the Contractor is not subject to a finding for recovery or it has taken the appropriate remedial steps required under section 9.24 of the Ohio Revised Code or it otherwise qualifies to contract with the State of Ohio under section 9.24 of the Ohio Revised Code.

17. **Licenses:** The Contractor certifies that all approvals, licenses, or other qualifications necessary to conduct business or, if applicable, practice law in Ohio have been obtained and are operative. If at any time during the IV-D Contract period the Contractor becomes disqualified or suspended from conducting business or, if applicable, practicing law in Ohio, the Contractor must immediately notify the CSEA of the disqualification or suspension and the Contractor will immediately cease performance of any obligations under this IV-D Contract.

18. **Independent Capacity for the Contractor:** The Contractor and its agents, employees, and subcontractors will act in performance of this IV-D Contract in an independent capacity and not as officers or employees or agents of the State of Ohio or the CSEA.

19. **Confidentiality:** The Contractor agrees that information regarding an individual shall only be used for purposes related to the IV-D program, in accordance with rules 5101:12-1-20 to 5101:12-1-20.2 of the Ohio Administrative Code. Disclosure of information for any other purpose is prohibited.

20. **Americans with Disabilities Act (ADA) Compliance:** The Contractor certifies that it is in full compliance with all statutes and regulations pertaining to the ADA of 1990 and with section 504 of the Rehabilitation Act of 1973.

21. **Civil Rights:** The Contractor certifies compliance with rule 5101:9-2-01 of the Ohio Administrative Code.

22. **Equal Employment Opportunity:** In carrying out this IV-D Contract, the Contractor shall not discriminate against any employee or applicant for employment because of race, religion, national origin, ancestry, color, sex, age, disability, or veteran status. The Contractor shall ensure that applicants are hired and that employees are treated during employment without regard to their race, religion, national origin, ancestry, color, sex, age, disability, or veteran status. Such action shall include but not be limited to the following: employment, upgrading, demotion, transfer, recruitment, recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship.

23. **Termination:** This IV-D Contract may be terminated:

23A. By mutual agreement at any time after the date on which the two parties reach their decision.

23B. If FFP reimbursement or the non-federal share designated for the purchase of services under this IV-D Contract is not available to the CSEA in an amount adequate to support the IV-D Contract as determined by the CSEA. When termination of the IV-D Contract occurs under this paragraph, the termination date is the date upon which the FFP reimbursement or non-federal share is no longer available; however, the CSEA may determine a later termination date. The CSEA shall provide the Contractor written notice of the termination but is not required to provide written notice in advance of the termination. Reimbursement to the Contractor will cease on the date of termination of the IV-D Contract.

23C. If the CSEA has discovered any illegal conduct on the part of the Contractor, immediately upon delivery of written notice to the Contractor by the CSEA.

23D. If the Contractor does not faithfully and promptly perform its responsibilities and obligations under this IV-D Contract as determined by the CSEA. If the CSEA elects to terminate the IV-D Contract, the CSEA shall provide the Contractor with written notice thirty days in advance of the termination date.

23E. If the CSEA does not faithfully and promptly perform its responsibilities and obligations under this IV-D Contract, as determined by the Contractor. If the Contractor elects to terminate the IV-D Contract, the Contractor shall provide the CSEA with written notice thirty days in advance of the termination date.

23F. If the IV-D Contract is for legal services and the Contractor becomes disqualified or suspended from conducting business or practicing law in Ohio, all obligations under this IV-D Contract shall immediately terminate and the

Contractor shall immediately notify the CSEA and cease the performance of any obligations under this IV-D Contract.

When the IV-D Contract terminates, the Contractor shall be entitled to compensation upon submission of the appropriate form(s), as described in paragraph 9, for the work performed prior to:

- The date on which the parties reached their decision, in accordance with paragraph 23A;
- The receipt of the written notice of termination, in accordance with paragraphs 23B through 23E; or
- The Contractor being disqualified or suspended from conducting business or practicing law, in accordance with paragraph 23F.

The CSEA shall calculate the compensation based on the Total IV-D Contract Cost less any funds previously paid by or on behalf of the CSEA. The Contractor shall not exceed the Total IV-D Contract Cost. The CSEA shall not be liable for any further claims.

IV-D Contract Signatures:

Signature of CSEA's Representative	Printed Name of CSEA's Representative
	Thomas Howard
Date of Signature 2-13-24	

Signature of Contractor's Representative	Printed Name of Contractor's Representative
	Joseph W. Kirby, Judge
Date of Signature 2/9/24	Printed Street Address of Contractor 900 Memorial Drive
Printed Title of Contractor's Representative Judge	Printed City, State, and Zip Code of Contractor Lebanon, Ohio 45036

Signature of County Commissioner or Representative	Date of Signature
*	2-20-24
Signature of County Commissioner or Representative *	Date of Signature 2-20-24
Signature of County Commissioner or Representative	Date of Signature
Signature of Prosecutor if required by County Commissioners	Date of Signature 2/8/24

Prosecuting Attorney
David P. Fornshell

CHILD SUPPORT ENFORCEMENT AGENCY
WARREN COUNTY, OHIO

Director, CSEA
Thomas E.A. Howard

500 Justice Drive • Lebanon, Ohio 45036
Phone: (513) 695-1580
Fax: (513) 695-2969
http://www.co.warren.oh.us/wcchildsupport

Re: **Performance Standards**

- Court shall provide a Magistrate for agreed upon dockets.
- Provided Magistrate shall be prepared to adjudicate all child support cases brought before him/her on said dockets. All cases on the dockets must have an active IV-D application on file with the Warren County Child Support Enforcement Agency. Further, any litigated issues must be IV-D reimbursable.
- Court shall provide the Magistrate with appropriate space and materials to properly adjudicate cases on said dockets.
- Magistrate shall expeditiously adjudicate all cases on said dockets.

Ohio Department of Job and Family Services

GOVERNMENTAL CONTRACTOR IV-D CONTRACT BUDGET

Summary Sheet		
County:	Warren County	
Governmental Contractor:	Juvenile Court	
Type of IV-D Contract:	Magistrate services	
I. Staff		Estimated Amount
	A. Salaries	$175,809.00
	B. Payroll Related Expenses	$67,368.67
	Total Staff Costs	$243,177.67
II. Operations		
	A. Travel and Short Term Training	$2,000.00
	B. Consumable Supplies	$0.00
	C. Occupancy Costs	$0.00
	D. Indirect Costs	$0.00
	E. Contract and Professional Services	$500.00
	F. Miscellaneous	$0.00
	Total Operations Costs	$2,500.00
III. Equipment		
	A. Equipment Subject to Depreciation	$0.00
	B. Equipment Purchases	$0.00
	C. Leased and Rented Equipment	$0.00
	Total Equipment Costs	$0.00
	Sub-Total of All Costs	$245,677.67
	IV. MINUS Fees Collected by the Contractor	
	Total Expenses	$245,677.67

I.A. Salaries

I.A.1. Principal Staff

Position Title	Total Annual Hours Paid by County	Annual Hours Worked In Contracted Office	Annual Salary	% of Salary Applied to Budget	Salary Applied to Budget
Magistrate 1	1820	1820	$99,681.00	100.00%	$99,681.00
Magistrate 2	1560	1560	$76,128.00	100.00%	$76,128.00

Notes:

I.A. Salaries

I.A.2. Support Staff

Position Title	Total Annual Hours Paid by County	Total Hours Spent Assisting Principal Staff	Annual Salary	% of Salary Applied to Budget	Salary Applied to Budget

I.A.3. Unassociated Staff

Position Title	

Total Salaries Applied to this Contract $175,809.00

I.B. Payroll Related Expenses

Type	Percentage	Salary	Amount Applied to Budget
OPERS or Social Security	14.00%	$175,809.00	$24,613.26
Workers' Compensation/Unemployment Insurance	2.00%	$175,809.00	$3,516.18
Retirement Expense/Medicare	1.45%	$175,809.00	$2,549.23
Hospitalization Insurance Premium			$35,826.00
Other Life Insurance			$264.00
Other HSA			$600.00
Other			
Other			
Other			
Other			
Total Payroll Related Expenses			$67,368.67

Notes:

II.A. Travel and Short Term Training

Type	Mileage rate	Miles	Amount Total mileage	Prorate %	Amount Applied to Budget
Mileage Reimbursement			$0.00		
Short Term Training			$2,000.00	100.00%	$2,000.00
Other					
Other					
Other					
Total Travel and Short Term Training					$2,000.00

Notes:
To subscribe to the Key Partner Membership, to attend any trainings or conferences such as the OCDA Spring Conference, OCDA Fall Conference or the OCDA Partner Conference

II.B. Consumable Supplies

Type	Amount	Prorate %	Amount Applied to Budget
Office Supplies			
Cleaning Supplies			
Other			
Other			
Other			
Other			
Other			
Total Consumable Supplies			$0.00

Notes:

II.C. Occupancy Costs

	Amount	Prorate %	Amount Applied to Budget
Rental at per square foot:	$0.00		
or			
Usage allowance/depreciation at % rate of original acquisition cost by Program Square Footage Percentage (Program Square Footage ÷ Provider Square Footage)			
Maintenance and Repairs			
Utilities (if not included in rent)			
Heat and Light			
Telephone			
Water			
Other:			
Other:			
Other:			
Total Occupancy Costs			$0.00

Notes:

II.D. Indirect Costs

Category	CAP Amount	Prorate %	Amount Applied to Budget
Total Indirect Costs			$0.00

Notes:

II.E. Contract & Professional Services

Type	Amount	Prorate %	Amount Applied to Budget
Transcripts	$500.00	100.00%	$500.00
Total Contract and Professional Services Costs			$500.00

Notes:

II.F. Miscellaneous

Description	Amount	Prorate %	Amount Applied to Budget
Total Miscellaneous Costs			$0.00

Notes:

III.A. Equipment Subject to Depreciation

Equipment to be Depreciated	New or Used	Purchase Date	Quantity	Total Actual Cost per Item	Salvage Value per Item	Total Amount to be Depreciated	Useful Life	Prorate %	Chargeable Amount of Depreciation
Total Equipment Depreciation Charges									$0.00

Notes:

III.B. Equipment Purchases

Item	Amount	Prorate %	Quantity	Amount Applied to Budget
Total Small Equipment Purchases				$0.00

Notes:

III.C. Lease and Rental Equipment

Item	Model and Year	Amount	Prorate %	Quantity	Amount Applied to Budget
Total Lease and Rental Equipment					$0.00

Notes:

BUDGET COMPUTATION WORKSHEET

Is this a IV-D Contract with a court for magistrate services in which a IV-D multiplier was used?

Select 1 or 2 ▶ 1

1 - no
2 - yes

Carried over from Page 1 ▼

$245,677.67	÷	3,380	=	$72.69
Total Expenses	Divided by	Total Operating Units Produced by Principal Staff	Equals	Unit Rate

$72.69	X	637	=	$46,300.79
Unit Rate	Multiplied by	Total Units of Service Purchased	Equals	100% Contract Value

Ohio Department of Job and Family Services

IV-D CONTRACT SECURITY ADDENDUM

By signing this form, the contractor agrees to comply with all of the terms and conditions described herein.

I. Ohio Department of Taxation Information

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

All Ohio Department of Taxation, taxpayer information concerning the residential address and income of taxpayers received by the contractor is needed for the purpose of and will be used only to the extent necessary in, locating obligors, or establishing, enforcing and collecting child support obligations pursuant to Part D, Title IV of the Social Security Act. None of the information so obtained will be disclosed except for official purposes as described in section 3125.43 of the Revised Code or in compliance with a court order.

II Federal Parent Locator Service Information (FPLS)

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

All information received by the contractor from FPLS is needed for the purpose of and will be used only to the extent necessary in, establishing and collecting child support obligations pursuant to Part D, Title IV of the Social Security Act. obligations or pursuant to a request in connection with a parental kidnapping or child custody case as described in federal regulations at 45 CFR 303.15 and 303.69. This information shall be treated as confidential.

III. Department of Job and Family Services, Office of Unemployment Compensation Information

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by his or her employees with the following requirements:

All information and records received from the Ohio Department of Job and Family Services, Office of Unemployment Compensation shall be used only for the purposes of establishing and collecting child support obligations from and locating individuals owing such obligations. The contractor maintains security safeguards for location, wage, and benefit information.

IV. Internal Revenue Service (IRS) Information

A. Performance

In performance of this contract, the contractor agrees to comply with and assume responsibility for compliance by officers or employees with the following requirements:

(1) All work will be performed under the supervision of the contractor.

(2) The contractor and the contractor's officers or employees to be authorized access to federal tax information (FTI) must meet background check requirements defined in IRS Publication 1075. The contractor will maintain a list of officers or employees authorized access to FTI. Such list will be provided to the agency and, upon request, to the IRS.

(3) FTI in hardcopy or electronic format shall be used only for the purpose of carrying out the provisions of this contract. FTI in any format shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this contract. Inspection or disclosure of FTI to anyone other than the contractor or the contractor's officers or employees authorized is prohibited.

(4) FTI will be accounted for upon receipt and properly stored before, during, and after processing. In addition, any related output and products require the same level of protection as required for the source material.

(5) The contractor will certify that FTI processed during the performance of this contract will be completely purged from all physical and electronic data storage with no output to be retained by the contractor at the time

the work is completed. If immediate purging of physical and electronic data storage is not possible, the contractor will certify that any FTI in physical or electronic storage will remain safeguarded to prevent unauthorized disclosures.

(6) Any spoilage or any intermediate hard copy printout that may result during the processing of FTI will be given to the agency. When this is not possible, the contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts and will provide the agency with a statement containing the date of destruction, description of material destroyed, and the destruction method.

(7) All computer systems receiving, processing, storing, or transmitting FTI must meet the requirements in IRS Publication 1075. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to FTI.

(8) No work involving FTI furnished under this contract will be subcontracted without the prior written approval of the IRS.

(9) Contractor will ensure that the terms of the FTI safeguards described herein are included, without modification, in any approved subcontract for work involving FTI.

(10) To the extent the terms, provisions, duties, requirements, and obligations of this contract apply to performing services with FTI, the contractor shall assume toward the subcontractor all obligations, duties and responsibilities that the agency under this contract assumes toward the contractor, and the subcontractor shall assume toward the contractor all the same obligations, duties and responsibilities which the contractor assumes toward the agency under this contract.

(11) In addition to the subcontractor's obligation and duties under an approved subcontract, the terms and conditions of this contract apply to the subcontractor, and the subcontractor is bound and obligated to the contractor hereunder by the same terms and conditions by which the contractor is bound and obligated to the agency under this contract.

(12) For purposes of this contact, the term "contractor" includes any officer or employee of the contractor with access to or who uses FTI, and the term "subcontractor" includes any officer or employee of the subcontractor with access to or who uses FTI.

(13) The agency will have the right to void the contract if the contractor fails to meet the terms of the FTI safeguards described herein.

B. Criminal and Civil Sanctions

(1) Each officer or employee of a contractor to whom FTI is or may be disclosed shall be notified in writing that FTI disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any FTI for a purpose not authorized herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as 5 years, or both, together with the costs of prosecution.

(2) Each officer or employee of a contractor to whom FTI is or may be accessible shall be notified in writing that FTI accessible to such officer or employee may be accessed only for a purpose and to the extent authorized herein, and that access/inspection of FTI without an officer need-to-know for a purpose not authorized herein constitutes a criminal misdemeanor punishable upon conviction by a fine of as much as $1,000 or imprisonment for as long as 1 year, or both, together with the costs of prosecution.

(3) Each officer or employee of a contractor to whom FTI is or may be disclosed shall be notified in writing that any such unauthorized access, inspection or disclosure of FTI may also result in an award of civil damages against the officer or employee in an amount equal to the sum of the greater of $1,000 for each unauthorized access, inspection, or disclosure, or the sum of actual damages sustained as a result of such unauthorized access, inspection, or disclosure, plus in the case of a willful unauthorized access, inspection, or disclosure or an unauthorized access/inspection or disclosure which is the result of gross negligence, punitive damages, plus the cost of the action. These penalties are prescribed by IRC sections 7213, 7213A and 7431 and set forth at 26 CFR 301.6103(n)-1.

(4) Additionally, it is incumbent upon the contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

(5) Granting a contractor access to FTI must be preceded by certifying that each individual understands the agency's security policy and procedures for safeguarding IRS information. Contractors must maintain their authorization to access FTI through annual recertification. The initial certification and recertification must be documented and placed in the agency's files for review. As part of the certification and at least annually afterwards, contractors must be advised of the provisions of IRCs 7431, 7213, and 7213A (see Exhibit 4, Sanctions for Unauthorized Disclosure, and Exhibit 5, Civil Damages for Unauthorized Disclosure). The training on the agency's security policy and procedures provided before the initial certification and annually thereafter must also cover the incident response policy and procedure for reporting unauthorized disclosures and data breaches. (See Section 10) For the initial certification and the annual recertifications, the contractor and each officer or employee must sign, either with ink or electronic signature, a confidentiality statement certifying their understanding of the security requirements.

C. Inspections

The IRS and the Agency, with 24-hour notice, shall have the right to send its inspectors into the offices and plants of the contractor to inspect facilities and operations performing any work with FTI under this contract for compliance with requirements defined in IRS Publication 1075. The IRS' right of inspection shall include the use of manual and/or automated scanning tools to perform compliance and vulnerability assessments of information technology (IT) assets that access, store, process or transmit FTI. Based on the inspection, corrective actions may be required in cases where the contractor is found to be noncompliant with FTI safeguard requirements.

Warren County Juvenile Court
Printed Name of Contractor or Company

Signature of Contractor's Representative — Date: 2/9/24

Joseph W. Kirby, Judge
Printed Name of Contractor's Representative

Signature of Witness — Date: 02/09/2024

Kevin Kincer
Printed Name of Witness

CSEA

CATEGORIES	2014 for use in 2016	2015 for use in 2017	2016 for use in 2018	2017 for use in 2019	2018 for use in 2020	2019 for use in 2021	2020 for use in 2022	2021 for use in 2023	2022 for use in 2024	Difference
Bldg Use	$ 9,540.00	$ 10,661.00	$ 10,637.00	$ 10,637.00	$ 18,953.00	$ 25,957.00	$ 27,915.00	$ 28,052.00	$ 28,052.00	$ -
Property Insurance	$ 2,142.00	$ 1,485.00	$ 1,572.00	$ 1,503.00	$ 476.00	$ 477.00	$ 492.00	$ 390.00	$ 473.00	$ 83.00
Insurance	$ 3,392.00	$ 1,988.00	$ 2,492.00	$ 2,017.00	$ 2,091.00	$ 1,995.00	$ 1,402.00	$ 2,674.00	$ 2,156.00	$ (518.00)
Commissioners	$ -	$ -							$ 1,817.00	$ 1,817.00
Bldg. Maintenance	$ 133,238.00	$ 143,509.00	$ 119,862.00	$ 126,371.00	$ 106,211.00	$ 103,719.00	$ 97,822.00	$ 78,759.00	$ 99,707.00	$ 20,948.00
OMB	$ 20,811.00	$ 20,822.00	$ 20,248.00	$ 24,419.00	$ 21,254.00	$ 22,915.00	$ 18,827.00	$ 19,188.00	$ 18,876.00	$ (312.00)
Vehicle Maintenance	$ -	$ -								$ -
Telecomm	$ 27,665.00	$ 42,067.00	$ 38,676.00	$ 43,771.00	$ 40,613.00	$ 50,797.00	$ 47,574.00	$ 41,865.00	$ 57,952.00	$ 16,087.00
Prosecutor	$ 11,423.00	$ 11,777.00	$ 12,425.00	$ 12,394.00	$ 12,576.00	$ 13,374.00	$ 13,992.00	$ 14,012.00	$ 14,841.00	$ 829.00
DP	$ 19,183.00	$ 15,594.00	$ 12,999.00	$ 39,599.00	$ 38,023.00	$ 44,173.00	$ 28,238.00	$ 23,391.00	$ 23,505.00	$ 114.00
Treasurer	$ 3,373.00	$ 3,307.00	$ 3,531.00	$ 4,089.00	$ 4,693.00	$ 4,800.00	$ 5,651.00	$ 4,770.00	$ 3,821.00	$ (949.00)
Auditor	$ 20,938.00	$ 17,083.00	$ 17,428.00	$ 19,167.00	$ 24,253.00	$ 21,413.00	$ 20,328.00	$ 20,262.00	$ 16,186.00	$ (4,076.00)
Total Allocated	$ 251,705.00	$ 268,293.00	$ 239,870.00	$ 283,967.00	$ 269,143.00	$ 289,620.00	$ 262,241.00	$ 233,363.00	$ 267,386.00	$ 34,023.00
Roll Forward	$ (3,277.00)	$ (942.00)	$ (11,835.00)	$ 15,674.00	$ 17,126.00	$ (6,641.00)	$ (6,902.00)	$ (56,257.00)	$ 5,145.00	$ 61,402.00
										$ -
Proposed Cost	$ 248,428.00	$ 267,351.00	$ 228,035.00	$ 299,641.00	$ 286,269.00	$ 282,979.00	$ 255,339.00	$ 177,106.00	$ 272,531.00	$ 95,425.00

2017 - Biggest Difference is in Telecomm. The Bd of DD has totally withdrawn from our system leaving fewer departments to spread the expenditures amongst.

2017 for use in 2019 - There was an increase within IT and the roll forward amount was a positive number verses in 2016 the roll forward was a negative number.

2020 for use in 2021 - decrease due to less employees, from 49 to 45

2021 for use in 2023 - decrease due to the Facilities allocation change from 2020

2023 for use in 2024 - increase in expenditures in Telecom and Facilities. Also, annual audit was in under Auditor - now under Commissioners - there is not an increase from this - just appears under the Commissioners line.

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0250 *Adopted Date* February 20, 2024

AUTHORIZING THE PRESIDENT OF THE BOARD TO SIGN A SOFTWARE AGREEMENT WITH BIDDLE CONSULTING GROUP, INC. ON BEHALF OF WARREN COUNTY OF EMERGENCY SERVICES

WHEREAS, Biddle Consulting Group will provide online testing software for the purpose of evaluating job applicants for Warren County Emergency Services.

NOW THEREFORE BE IT RESOLVED, to authorize the President of the Board to sign a software license agreement with Biddle Consulting Group, Inc. relative to CritiCall Online Testing Software, CritiCall Personality Testing, and TrueNorth Language Testing for the purpose of evaluating job applicants for Warren County Emergency Services. Copy of said agreement is attached hereto and made a part hereof.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: c/a—Biddle Consulting Group, Inc.
Emergency Services (file)

Biddle Consulting Group, Inc
193 Blue Ravine Road, Suite 270
Folsom, CA. 95630-4760
(916) 294-4250
www.biddle.com

CritiCall® ONLINE Annual License Price Quote

Please see the following price quote for Annual License of the CritiCall Online Testing Software with CritiCall Personality Testing and TrueNorth Language Testing. This license allows you to test an unlimited number of your candidates remotely or in groups of any size at your center.

Warren County Emergency Services
520 Justice Drive
Lebanon, OH 45036

Price Quote Valid Through February 29, 2024

CritiCall ONLINE Annual License Fee	$5,725.00	Annual fee for unlimited ONLINE and proctored CritiCall Testing Plus CritiCall Personality Testing and TrueNorth Language Testing
CritiCall Elite Premium Customer Service Support	INCLUDED	Includes Technical Support, Training and Upgrades
TOTAL VALUE	$5,725.00	Billed Net 30

Kim Ward
Sr. Account Executive/CritiCall Software
Biddle Consulting Group, Inc.
193 Blue Ravine Road, Suite 270
Folsom, CA 95630-4760
(800)999-0438 ext. 139
kward@biddle.com

biddle consulting group

193 Blue Ravine Rd, Suite 270
Folsom, CA 95630

800 999 0438

biddle.com

TestGenius Terms of Use

1. GRANT OF LICENSE: Biddle Consulting Group, Inc., (BCG) and Logi-Serve, LLC, (hereafter referred to as "LICENSOR") grants to the end-user client (hereinafter referred to as "LICENSEE") the right to use the TestGenius (which may include licenses for CritiCall and/or OPAC and/or C4 and/or Logi-Serve OnDemand Assessments) Software (hereinafter referred to as "SOFTWARE"). LICENSOR reserves all rights not expressly granted to LICENSEE in this legal document. SOFTWARE is licensed for use by the LICENSEE organization alone. This license may not be extended to any other organization. Unlimited Annual-License Grant. If the LICENSEE has purchased an unlimited annual-license, LICENSOR grants to the LICENSEE a nonexclusive license to access to SOFTWARE by multiple authorized simultaneous users within the LICENSEE organization. This Annual License Agreement allows SOFTWARE to operate through the licensed time-period and then cease to function. Annual relicensing will be necessary in order for continued use of SOFTWARE. It is the responsibility of LICENSEE to export data that LICENSEE may wish to access later in the event that LICENSEE opts to allow an annual license to expire. LICENSEE is authorized to use SOFTWARE for testing and/or training applicants or employees at the licensed organization only. It is an express violation of the license agreement to allow use of SOFTWARE by any other unlicensed organization. As such, LICENSEE is not authorized to use SOFTWARE as part of a "testing/certification service" for applicants or employees, unless expressly licensed for such use.

2. COPYRIGHT. LICENSOR retains title and ownership of the SOFTWARE. The SOFTWARE and the accompanying written materials are protected by United States copyright laws and international treaty provisions. Therefore, LICENSEE must treat SOFTWARE like any other copyrighted material (e.g. a book or musical recording.)

3. USE RESTRICTION. LICENSEE may not distribute licenses of or access to SOFTWARE or accompanying written materials to other parties. LICENSEE may not modify, adapt, translate, reverse engineer, decompile, disassemble, or create derivative works based on the SOFTWARE.

4. TRANSFER RESTRICTIONS. LICENSEE may not rent or lease SOFTWARE.

5. LIABILITY. Each party to this Agreement agrees to be liable for the negligent acts or negligent omissions, intentional or wrongful acts or omissions, by or through itself, its employees and agents. Each party further agrees to defend itself and themselves and pay any judgments and costs arising out of such negligent, intentional, or wrongful acts or omissions, and nothing in this Agreement shall impute or transfer any such liability from one to the other.

biddle
consulting group

6. TERMINATION. This License is effective until terminated. This License may be terminated at any time with or without cause by either party upon thirty (30) days written notice to the other party. This License will terminate automatically without notice from LICENSOR if LICENSEE fails to comply with any provision of this License.

7. GOVERNING LAW. This agreement is subject to, and will be governed by, and construed in accordance with the substantive laws in force of the County of Warren, State of Ohio which shall have exclusive jurisdiction over any disputes except in matters of conflict of laws.

8. LIMITED WARRANTY. LICENSOR warrants that, for a period of thirty (30) days from the date of delivery, SOFTWARE will perform substantially in accordance with the Operator's Manual.

9. CUSTOMER REMEDIES. LICENSOR's entire liability and LICENSEE's exclusive remedy shall cancellation of the license and return of the license fee for the unused portion of the license. THESE REMEDIES ARE NOT AVAILABLE OUTSIDE OF THE UNITED STATES OF AMERICA OR CANADA.

10. NO OTHER WARRANTIES. The foregoing warranties are in lieu of all other warranties, either express of implied, including but not limited to implied warranties of merchantability and fitness for a particular purpose, with respect to SOFTWARE, the accompanying written materials, and other media. Due to the myriad of factors that impact the outcomes of EEO-related litigation, LICENSOR does not guarantee that the work done by its employees or officers or its products will bear successful outcomes in audits or litigation. LICENSOR will at all times operate in a professional manner to provide the highest quality of service possible. No other warranty or representation, either expressed or implied, is included in the work prepared by LICENSOR or its products. The parties agree that the aggregate liability of the LICENSOR and any other persons or entities arising from performance of this Agreement on account of any and all injury or damage to person or property, any defect, error, omission, or professional negligence, including cost of defense and attorney fees, will be limited to a sum not exceeding the license fees collected.

11. NO LIABILITY FOR CONSEQUENTIAL DAMAGES. In no event shall LICENSOR or its suppliers be liable for any damages whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of business information, or other pecuniary loss) arising out of the use of or inability to use SOFTWARE, even if LICENSOR has been advised of the possibility of such damages.

Should there be any questions concerning this Agreement, contact BCG at 193 Blue Ravine Road, Suite 270, Folsom, CA 95630. www.biddle.com : www.testgenius.com : staff@biddle.com : 916-294-4250

David G. Yard, President

Michael Callen, VP of Products
2/7/2024

APPROVED AS TO FORM

Derek B. Faulkner
Asst. Prosecuting Attorney

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0251 *Adopted Date* February 20, 2024

RESCINDING RESOLUTION 24-0221 AND ADOPTING NEW RESOLUTION ENTERING INTO A COOPERATIVE AGREEMENT WITH THE BOARD OF COUNTY COMMISSIONERS OF HAMILTON COUNTY, OHIO, AND THE WARREN COUNTY TID FOR CONSTRUCTION OF IMPROVEMENTS TO FIELDS ERTEL ROAD BETWEEN SNIDER ROAD AND WILKENS BOULEVARD

WHEREAS, the Warren County Engineer submitted a cooperative agreement between Warren County, the Warren County Transportation Improvement District and Hamilton County for Construction of Improvements to Fields Ertel Road between Snider Road and Wilkens Boulevard, Project No. 501715 as part of Resolution 24-0221 with incorrect funding amounts for Hamilton County and Warren County; and

WHEREAS, upon the recommendation of the Warren County Engineer, Resolution 24-0221 should be rescinded to correct the funding amount for the respective County's portion.

NOW THEREFORE BE IT RESOLVED, to rescind Resolution 24-0221 and to approve and authorize the President of the Board to execute the attached corrected cooperative agreement between Warren County, the Warren County Transportation Improvement District and Hamilton County for Construction of Improvements to Fields Ertel Road between Snider Road and Wilkens Boulevard, Project No. 501715.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: c/a—Warren County Transportation Improvement District (file)
c/a—Hamilton County
Engineer (file)
Hamilton County Engineer

AMENDMENT NO. 3 TO JOINT AGREEMENT BETWEEN HAMILTON COUNTY AND WARREN COUNTY FOR THE ACQUISTION AND CONSTRUCTION OF IMPROVEMENTS TO FIELDS ERTEL ROAD BETWEEN SNIDER ROAD AND WILKENS BOULEVARD

PROJECT No. 501715

The JOINT AGREEMENT entered into on March 21, 2018, and as amended on February 2, 2021 and September 28, 2021, by and between the Board of County Commissioners of Hamilton County, Ohio, hereinafter referred to as "HAMILTON COUNTY", on behalf of the Hamilton County Engineer, hereinafter referred to as the "HAMILTON COUNTY ENGINEER", and the Board of County Commissioners of Warren County, Ohio, hereinafter referred to as "WARREN COUNTY", on behalf of the Warren County Engineer, hereinafter referred to as the "WARREN COUNTY ENGINEER", is hereby further amended as follows:

HAMILTON COUNTY, WARREN COUNTY and THE WARREN COUNTY TRANSPORTATION IMPROVEMENT DISTRICT, hereinafter referred to as the "WCTID" agree:

1) The WCTID is hereby added as a party to the Joint Agreement, pursuant to Ohio Revised Code Sections 5540.02 (F); 5540.03 (A)(4), (8), (10), (13), and (14); and, 5540.18 and other applicable sections, and in accordance therewith HAMILTON COUNTY, WARREN COUNTY and THE WARREN COUNTY TRANSPORTATION IMPROVEMENT DISTRICT (collectively referred to hereinafter as the "Parties") acknowledge and agree that the WCTID shall oversee and administer, in coordination and cooperation with the WARREN COUNTY ENGINEER and the HAMILTON COUNTY ENGINEER, the construction phase of the Fields-Ertel Road between Snider Road and Wilkens Blvd Project ("PROJECT"), including, but not limited to, advertising for bids, accepting bids and awarding a construction services contract for constructing the PROJECT improvements in accordance with and as further set forth in plans and documents on file with the WARREN COUNTY ENGINEER, the HAMILTON COUNTY ENGINEER and the WCTID and as further authorized by the WCTID Board of Trustees at such times as appropriate and upon confirmation by the WCTID of the availability of the required PROJECT funding as further set forth herein.

2) PROJECT construction cost is currently estimated to be in the total amount of $16,866,486.41, which includes, but is not limited to, construction administration, utility relocation, and labor and materials to construct the PROJECT.

3) WARREN COUNTY in coordination with HAMILTON COUNTY applied for and obtained federal Surface Transportation Block Grant funds in the amount of $5,940,000.00 allocated by the Ohio Kentucky Indiana Regional Council of Governments ("OKI") to be applied towards the PROJECT construction costs, which OKI funding requires a local match share of 25% from HAMILTON COUNTY, in the amount of $ 2,970,000.00 (the "HAMILTON COUNTY SHARE") and of 25% from WARREN COUNTY, in the amount of $2,970,000.00 (the "WARREN COUNTY SHARE"), for a total local match share amount of $5,940,000.00.

4) The HAMILTON COUNTY ENGINEER has applied for and obtained an Ohio Public Works Commission ("OPWC") grant in the amount of $3,330,850.00 for PROJECT construction costs, which will be credited towards the HAMILTON COUNTY SHARE of the required local match cost (the "Hamilton County OPWC Credit").

5) The WARREN COUNTY ENGINEER also applied for and obtained an OPWC grant in the amount of $800,000.00 for PROJECT construction costs which will be credited towards the required WARREN COUNTY SHARE of the local match cost (the "Warren County OPWC Credit").

6) The Parties further acknowledge, agree, ratify and confirm that the WCTID will act as the Ohio Department of Transportation ("ODOT") designated Local Public Agency ("LPA") for the Project and the WCTID, by and through its Board of Trustees shall take all actions and follow the requirements and regulations mandated by ODOT in its capacity as the Project LPA for implementing, managing and inspecting the construction phase of the Project, in coordination and cooperation with the WARREN COUNTY ENGINEER, the HAMILTON COUNTY ENGINEER and in accordance with the ODOT LPA agreement and other provisions of applicable law, to be entered into between ODOT and the WCTID upon confirmation of the availability of the HAMILTON COUNTY SHARE and the WARREN COUNTY SHARE.

7) The WCTID will invoice HAMILTON COUNTY for the remaining amount of the HAMILTON COUNTY SHARE, after application of the OPWC Credit, in two (2) installment payments in amounts of $1,027,585.11 and $1,000,000.00 and HAMILTON COUNTY shall deposit the installment amounts with the WCTID on or before the June 1, 2024, and on or before February 1, 2025, respectively.

8) The WCTID will invoice WARREN COUNTY for the remaining amount of the WARREN COUNTY SHARE, after application of the OPWC Credit, in the amount of $4,558,435.11 and WARREN COUNTY shall deposit this amount with the WCTID on or before the June 1, 2024.

9) Each contractor pay request will be approved by the HAMILTON COUNTY ENGINEER, the WARREN COUNTY ENGINEER and the WCTID. Within 45 days after the contractor's final pay request is issued, excess funds will be returned, or final invoice will be issued for payment of any overruns to Hamilton County and Warren County.

This AMENDMENT NO. 3 TO JOINT AGREEMENT shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

All other obligations of the Joint Agreement shall remain in full force and effect, except as provided herein. In the event any conflict or dispute arises between the Joint Agreement and this Amendment, such conflict or dispute shall be resolved in accordance with the amended obligations set forth in this Amendment.

WARREN COUNTY:

IN EXECUTION WHEREOF, upon written recommendation of the Warren County Engineer, the Warren County Board of County Commissioners has caused this Agreement to be executed on the date stated below by David G. Young, its President, pursuant to Resolution No. 24-0251, dated ~~February 20,~~ February 2024.

RECOMMENDED BY:

WARREN COUNTY ENGINEER

BY: Neil F. Tunison

NAME: Neil F. Tunison, P.E., P.S.

TITLE: County Engineer

DATE: 2/15/2024

AGREED TO BY:
BOARD OF COMMISSIONERS
OF WARREN COUNTY, OHIO

BY: DGY

NAME: David G. Young

TITLE: President

DATE: 2-20-24

Approved as to Form:
DAVID P. FORNSHELL, PROSECUTING ATTORNEY
WARREN COUNTY, OHIO

BY: _____
Assistant Prosecutor

HAMILTON COUNTY:

By: _____
County Engineer

Board of County Commissioners, Hamilton County, Ohio:

By: _____
County Administrator

Approved as to Form:

By: _____
Assistant County Prosecutor

THE WARREN COUNTY TRANSPORTATION IMPROVEMENT DISTRICT:

By: _____
Chairperson, WCTID Board of Trustees

Approved as to Form:

By: _____
WCTID Legal Counsel

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0252 *Adopted Date* February 20, 2024

ACCEPTING PERMANENT AND TEMPORARY EASEMENT AGREEMENTS WITH STEVEN J. AND MARGO K. KOMAREK FOR THE STEPHENS ROAD BRIDGE #158-0.92 REPLACEMENT PROJECT

WHEREAS, in order to improve Stephens Road Bridge #158-0.92 it is necessary to construct a bridge replacement project and in order to do this work it is necessary to enter onto property, which is owned by Steven J. and Margo K. Komarek, grantors; and

WHEREAS, in order to accomplish the foregoing, it is necessary to obtain permanent easement and temporary construction easements from the property owner; and

WHEREAS, the land for the permanent and temporary easements are as follows:

- Permanent Easement – 3-SH1- 0.0816 acres
- Permanent Easement – 3-SH2- 0.0033 acres
- Temporary Easement – 3T1- 0.0119 acres
- Temporary Easement – 3T2- 0.0625 acres

WHEREAS, the negotiated price for the permanent and temporary easements is $6,643.00.

NOW THEREFORE BE IT RESOLVED, to accept permanent and temporary easement agreements, copies of which are attached hereto and made a part hereof, with Steven J. and Margo K. Komarek for the Stephens Road Bridge Replacement project for the sum of $6,643.00.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: c/a—Komarek, Steven J. & Margo K.
Engineer (file)
Easement file
Recorder (certified)

LPA RE 804
Rev. 04/2021

E
LPA

EASEMENT

Steven J. Komarek and Margo K. Komarek, husband and wife, the Grantor(s), in consideration of the sum of $5,675.00, to be paid by the Warren County Board of County Commissioners, the Grantee, do convey(s) to Grantee, its successors and assigns, an easement, which is more particularly described in Exhibit A attached, the following described real estate:

PARCEL(S): 3-SH1, 3-SH2

WAR-TR158-0.92

SEE EXHIBIT A ATTACHED

Warren County Current Tax Parcel No. 17-34-200-054 (Pt.)
Prior Instrument Reference: Doc. # 2021-010555, Warren County Recorder's Office.

Grantor(s), for themselves and their successors and assigns, covenant(s) with the Grantee, its successors and assigns, that they are the true and lawful owner(s) in fee simple, and have the right and power to convey the property and that the property is free and clear from all liens and encumbrances, except: (a) easements, restrictions, conditions, and covenants of record; (b) all legal highways; (c) zoning and building laws, ordinances, rules, and regulations; and (d) any and all taxes and assessments not yet due and payable; and that Grantor(s) will warrant and defend the property against all claims of all persons.

The property conveyed is being acquired by Grantee for a public purpose, namely the establishment, construction, reconstruction, widening, repair or maintenance of a public road.

In the event that the Grantee decides not to use the property conveyed for the above-stated purpose, the Grantor has a right under Section 163.211 of the Revised Code to repurchase the property for its fair market value as determined by an independent appraisal made by an appraiser chosen by agreement of the parties or, if the parties cannot agree, an appraiser chosen by an appropriate court. However, this right to repurchase will be extinguished if any of the following occur: (A) Grantor declines to repurchase the property; (B) Grantor fails to repurchase the property within sixty days after Grantee offers the property for repurchase; (C) Grantee grants or transfers the property to any other person or agency; or (D) Five years have passed since the property was appropriated.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

IN EXECUTION WHEREOF, Steven J. Komarek and Margo K. Komarek, husband and wife, have hereunto set their hands on the 29 day of January, 2024.

STEVEN J. KOMAREK

MARGO K. KOMAREK

STATE OF OHIO, COUNTY OF Warren SS:

BE IT REMEMBERED, that on the 29th day of January, 2024, before me the subscriber, a Notary Public in and for said state and county, personally came the above named Steven J. Komarek and Margo K. Komarek, who acknowledged the foregoing instrument to be their voluntary acts and deeds. This is not a jurat. This notarial act is in compliance with R.C. 147.542 (D)(1).

NOTARY PUBLIC
My Commission expires: Jan 31, 2026

NOTARY PUBLIC STATE OF OHIO

ERIC N. LUTZ
Notary Public, State of Ohio
My Comm. Expires Jan. 31, 2026

Prepared by: Warren County, Ohio
406 Justice Drive
Lebanon, OH 45036

SR159-10 R
17-G
9-28-2023

EXHIBIT A

LPA RX 871 SH

Rev. 06/09

Ver. Date 09/27/2023

PID 117643

PARCEL 3-SH1
WAR-TR158-0.92
PERPETUAL EASEMENT FOR HIGHWAY PURPOSES
WITHOUT LIMITATION OF EXISTING ACCESS RIGHTS
IN THE NAME AND FOR THE USE OF THE
WARREN COUNTY BOARD OF COUNTY COMMISSIONERS, WARREN COUNTY, OHIO

An exclusive perpetual easement for public highway and road purposes, including, but not limited to any utility construction, relocation and/or utility maintenance work deemed appropriate by the Warren County Board Of **County Commissioners, Warren** County, Ohio, its successors and assigns forever.

Grantor/Owner, for himself and his heirs, executors, administrators, successors and assigns, reserves all existing rights of ingress and egress to and from any residual area (as used herein, the expression "Grantor/Owner" includes the plural, and words in the masculine include the feminine or neuter).

[Surveyor's description of the premises follows]

Situated in Military Survey No. 3334, Hamilton Township, Warren County, State of Ohio, and being part of a 5.067-acre tract of land as conveyed to STEVEN J. KOMAREK and MARGO K. KOMAREK, by instrument as recorded in Doc. No. 2021-010555 of the Official Records of said county, and being more particularly bounded and described as follows:

Being a parcel of land lying on the left side of the existing centerline of TR158 (Stephens Road) as shown on the "WAR-TR158-0.92 (Stephens Road) Centerline Plat" part of the Right of Way plans for WAR-TR158-0.92 (Stephens Road) on file in the Warren County Engineer's Office:

Beginning for reference at an iron pin set in a centerline monument box set at centerline station 45+00.00;

Thence with said centerline South 83° 17' 26" East along the centerline of TR158 (Stephens Road) (40') 442.12 feet to the southwest corner of said 5.067-acre tract of land and the southeast corner of a 10.700-acre tract of land as conveyed to DAVID W. MAILE and DONNA G. MAILE, by instrument as recorded in OR 428, Page 679, said corner being at centerline station 49+42.12;

Thence with the west line of said 5.067-acre tract and the east line of said 10.700-acre tract North 10° 38' 19" East 20.05 feet to a point in the existing north right of way line for TR158, 20.00 feet left of centerline station 49+43.49, and being the TRUE POINT OF BEGINNING;

PARCEL 3-SH1

Thence continuing with said lines North 10° 38' 19" East 5.01 feet to a point 25.00 feet left of centerline Station 49+43.84;

Thence along new lines through said 5.067-acre tract for the following five courses:

1. South 83° 17' 26" East 16.16 feet to a point 25.00 feet left of centerline Station 49+60.00;
2. North 76° 09' 12" East 42.72 feet to a point 40.00 feet left of centerline Station 50+00.00;
3. North 06° 42' 34" East 15.00 feet to a point 55.00 feet left of centerline Station 50+00.00;
4. South 83° 17' 26" East 85.00 feet to a point 55.00 feet left of centerline Station 50+85.00;
5. South 06° 42' 34" West 35.00 feet to a point in the existing north right of way line of TR158, 20.00 feet left of centerline Station 50+85.00;

Thence with said line North 83° 17' 26" West 141.51 feet to the TRUE POINT OF BEGINNING, containing 0.0816 acres, (3557 SF), more or less, and subject to all legal easements and restrictions of record.

This description is based upon a field survey performed by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548, in April 2023, with bearings based upon the Ohio State Plane Coordinates, South Zone, NAD83 (2011), by GPS utilizing ODOT VRS, and conventional surveying.

This description was prepared by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548. The survey record of which is filed in Vol. 159, Plat 10 of the Warren County Engineer's record of land surveys.

EXHIBIT A

LPA RX 871 SH

Rev. 06/09

PARCEL 3-SH1 cont'd

Monument Boxes referred to as "set" are Centerline Monument Box assemblies to be set during construction, containing a 1" Iron pin to be set by the contractor's registered surveyor.

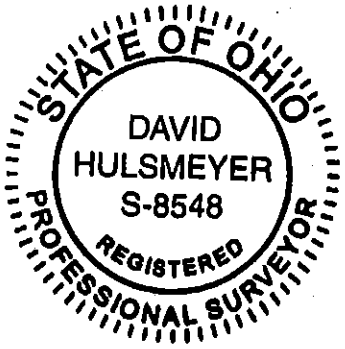
Evidence of occupation supports the monumentation found in the field and the property lines recited in this description.

Grantor claims title through instrument of record in Doc. No. 2021-010555, Warren County Recorder's Office.

0.0816 acres of the above-described area is contained within Warren County Auditor's Parcel Number 17-34-200-054, of which the present road right of way occupies 0.0000 acres, more or less.

Prepared by
LJB Inc.

By: David A. Hulsmeyer 9/27/23
David A. Hulsmeyer, Ohio PS No. 8548 Date



S.R.159-10 R
17-G
9-28-2023

EXHIBIT A

LPA RX 871 SH

Rev. 06/09

Ver. Date 09/27/2023

PID 117643

PARCEL 3-SH2
WAR-TR158-0.92
PERPETUAL EASEMENT FOR HIGHWAY PURPOSES
WITHOUT LIMITATION OF EXISTING ACCESS RIGHTS
IN THE NAME AND FOR THE USE OF THE
WARREN COUNTY BOARD OF COUNTY COMMISSIONERS, WARREN COUNTY, OHIO

An exclusive perpetual easement for public highway and road purposes, including, but not limited to any utility construction, relocation and/or utility maintenance work deemed appropriate by the Warren County Board Of **County Commissioners, Warren** County, Ohio, its successors and assigns forever.

Grantor/Owner, for himself and his heirs, executors, administrators, successors and assigns, reserves all existing rights of ingress and egress to and from any residual area (as used herein, the expression "Grantor/Owner" includes the plural, and words in the masculine include the feminine or neuter).

[Surveyor's description of the premises follows]

Situated in Military Survey No. 3334, Hamilton Township, Warren County, State of Ohio, and being part of a 5.067-acre tract of land as conveyed to STEVEN J. KOMAREK and MARGO K. KOMAREK, by instrument as recorded in Doc. No. 2021-010555 of the Official Records of said county, and being more particularly bounded and described as follows:

Being a parcel of land lying on the left side of the existing centerline of TR158 (Stephens Road) as shown on the "WAR-TR158-0.92 (Stephens Road) Centerline Plat" part of the Right of Way plans for WAR-TR158-0.92 (Stephens Road) on file in the Warren County Engineer's Office:

Beginning for reference at an iron pin set in a centerline monument box set at centerline station 45+00.00;

Thence with said centerline South 83° 17' 26" East along the centerline of TR158 (Stephens Road) (40') 442.12 feet to the southwest corner of said 5.067-acre tract of land and the southeast corner of a 10.700-acre tract of land as conveyed to DAVID W. MAILE and DONNA G. MAILE, by instrument as recorded in OR 428, Page 679, said corner being at centerline station 49+42.12;

Thence with the west line of said 5.067-acre tract and the east line of said 10.700-acre tract North 10° 38' 19" East 20.05 feet to a point in the existing north right of way line for TR158, 20.00 feet left of centerline station 49+43.49;

Thence with said existing north right of way line South 83° 17' 26" East 261.01 feet to a point 20.00 feet left of centerline station 52+04.50, and being the TRUE POINT OF BEGINNING;

PARCEL 3-SH2

Thence along new lines through said 5.067-acre tract for the following three courses:

1. North 06° 42' 34" East 12.00 feet to a point 32.00 feet left of centerline Station 52+04.50;

2. South 83° 17' 26" East 12.00 feet to a point 32.00 feet left of centerline Station 52+16.50;

3. South 06° 42' 34" West 12.00 feet to a point in the existing north right of way line of TR158, 20.00 feet left of centerline Station 52+16.50;

Thence with said line North 83° 17' 26" West 12.00 feet to the TRUE POINT OF BEGINNING, containing 0.0033 acres, (144 SF), more or less, and subject to all legal easements and restrictions of record.

This description is based upon a field survey performed by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548, in April 2023, with bearings based upon the Ohio State Plane Coordinates, South Zone, NAD83 (2011), by GPS utilizing ODOT VRS, and conventional surveying.

This description was prepared by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548. The survey record of which is filed in Vol. 159, Plat 10 of the Warren County Engineer's record of land surveys.

Monument Boxes referred to as "set" are Centerline Monument Box assemblies to be set during construction, containing a 1" Iron pin to be set by the contractor's registered surveyor.

Evidence of occupation supports the monumentation found in the field and the property lines recited in this description.

EXHIBIT A

LPA RX 871 SH

Rev. 06/09

PARCEL 3-SH2 cont'd

Grantor claims title through instrument of record in Doc. No. 2021-010555, Warren County Recorder's Office.

0.0033 acres of the above described area is contained within Warren County Auditor's Parcel Number 17-34-200-054, of which the present road right of way occupies 0.0000 acres, more or less.

Prepared by
LJB Inc.

By: David A. Hulsmeyer 9/27/23
David A. Hulsmeyer, Ohio PS No. 8548 Date

LPA RE 807
Rev. 10/2017

TE
LPA

TEMPORARY EASEMENT

Steven J. Komarek and Margo K. Komarek, husband and wife, the Grantor(s), in consideration of the sum of $968.00, to be paid by the Warren County Board of County Commissioners, the Grantee, do grant to Grantee the temporary easement(s) to exclusively occupy and use for the purposes mentioned in Exhibit A the following described real estate:

PARCEL(S): 3-T1, 3-T2

WAR-TR158-0.92

SEE EXHIBIT A ATTACHED

Warren County Current Tax Parcel No. 17-34-200-054 (Pt.)
Prior Instrument Reference: Doc. # 2021-010555, Warren County Recorder's Office.

To have and to hold the temporary easement(s), for the aforesaid purposes and for the anticipated period of time described below, unto the Grantee, its successors and assigns.

The duration of the temporary easement(s) granted to the Grantee is Twenty Four (24) months immediately following the date on which the work described above is first commenced by the Grantee, or its duly authorized employees, agents, and contractors, or December 31, 2025, whichever comes first.

The temporary easement(s) interest granted is being acquired by Grantee for a public purpose, namely the establishment, construction, reconstruction, widening, repair or maintenance of a public road.

IN EXECUTION WHEREOF, Steven J. Komarek and Margo K. Komarek, husband and wife, have hereunto set their hands on the date stated below.

STEVEN J. KOMAREK

DATE: 1/29/2024

MARGO K. KOMAREK

DATE: 01/29/2024

STATE OF OHIO, COUNTY OF Warren SS:

BE IT REMEMBERED, that on the 29th day of January, 2024, before me the subscriber, a Notary Public in and for said state and county, personally came the above named Steven J. Komarek and Margo K. Komarek, who acknowledged the foregoing instrument to be their voluntary acts and deeds. This is not a jurat. This notarial act is in compliance with R.C. 147.542 (D)(1).

NOTARY PUBLIC

My Commission expires: Jan 31, 2026

Prepared by: Warren County, Ohio
406 Justice Drive
Lebanon, OH 45040

NOTARY PUBLIC STATE OF OHIO

ERIC N. LUTZ
Notary Public, State of Ohio
My Comm. Expires Jan. 31, 2026

SR159-10
17-G
8/30/2023

EXHIBIT A

LPA RX 887 T

Rev. 07/09

Ver. Date 08/25/2023

PID 117643

PARCEL 3-T1
WAR-TR158-0.92
TEMPORARY EASEMENT FOR THE PURPOSE OF PERFORMING THE WORK NECESSARY TO PERFORM GRADING
FOR 24 MONTHS FROM DATE OF ENTRY BY THE WARREN COUNTY BOARD OF COUNTY COMMISSIONERS, WARREN COUNTY, OHIO

[Surveyor's description of the premises follows]

Situated in Military Survey No. 3334, Hamilton Township, Warren County, State of Ohio, and being part of a 5.067-acre tract of land as conveyed to STEVEN J. KOMAREK and MARGO K. KOMAREK, by instrument as recorded in Doc. No. 2021-010555 of the Official Records of said county, and being more particularly bounded and described as follows:

Being a parcel of land lying on the left side of the existing centerline of TR158 (Stephens Road) as shown on the "WAR-TR158-0.92 (Stephens Road) Centerline Plat" part of the Right of Way plans for WAR-TR158-0.92 (Stephens Road) on file in the Warren County Engineer's Office:

Beginning for reference at the southwest corner of said 5.067-acre tract, said corner being at centerline station 49+42.12;

Thence with the west line of said 5.067-acre tract North 10° 38' 19" East 25.06 feet to a point in the new north right of way line for TR158 (Stephens Road) (40'), 25.00 feet left of centerline station 49+43.84, and being the TRUE POINT OF BEGINNING;

PARCEL 3-T1

Thence with the west line of said tract North 10° 38' 19" East 11.15 feet to a point 36.12 feet left of centerline Station 49+44.60;

Thence along a new line into said tract South 76° 42' 31" East 18.52 feet to a point 34.00 feet left of centerline Station 49+63.00;

Thence along a new line into said tract North 73° 19' 27" East 40.31 feet to a point in the new north right of way line of TR158, 50.00 feet left of centerline Station 50+00.00;

Thence with said new north right of way line for the following three courses:

PARCEL 3-T1 cont'd

1. South 06° 42' 34" West 10.00 feet to a point 40.00 feet left of centerline Station 50+00.00;

2. South 76° 09' 12" West 42.72 feet to a point 25.00 feet left of centerline Station 49+60.00;

3. North 83° 17' 26" West 16.16 feet to the TRUE POINT OF BEGINNING; containing 0.0119 acres, (518 SF), more or less, and subject to all legal easements and restrictions of record.

This description is based upon a field survey performed by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548, in April 2023, with bearings based upon the Ohio State Plane Coordinates, South Zone, NAD83 (2011), by GPS utilizing ODOT VRS, and conventional surveying.

This description was prepared by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548. The survey record of which is filed in Vol. _____, Plat _____ of the Warren County Engineer's record of land surveys.

Monument Boxes referred to as "set" are Centerline Monument Box assemblies to be set during construction, containing a 1" Iron pin to be set by the contractor's registered surveyor.

Evidence of occupation supports the monumentation found in the field and the property lines recited in this description.

Grantor claims title through instrument of record in Doc. No. 2021-010555, Warren County Recorder's Office.

EXHIBIT A

LPA RX 887 T

Rev. 07/09

PARCEL 3-T1 cont'd

0.0119 acres of the above-described area is contained within Warren County Auditor's Parcel Number 17-34-200-054, of which the present road right of way occupies 0.0000 acres, more or less.

STATE OF OHIO
DAVID
HULSMEYER
S-8548
REGISTERED
PROFESSIONAL SURVEYOR

Prepared by
LJB Inc.

By: David A. Hulsmeyer 8/25/2023
David A. Hulsmeyer, Ohio PS No. 8548 Date

S.R.159-10 R
17-G
9-28-2023

EXHIBIT A

LPA RX 887 T

Rev. 07/09

Ver. Date 09/27/2023

PID 117643

PARCEL 3-T2
WAR-TR158-0.92
TEMPORARY EASEMENT FOR THE PURPOSE OF PERFORMING THE WORK NECESSARY TO PERFORM GRADING
FOR 24 MONTHS FROM DATE OF ENTRY BY THE WARREN COUNTY BOARD OF COUNTY COMMISSIONERS, WARREN COUNTY, OHIO

[Surveyor's description of the premises follows]

Situated in Military Survey No. 3334, Hamilton Township, Warren County, State of Ohio, and being part of a 5.067-acre tract of land as conveyed to STEVEN J. KOMAREK and MARGO K. KOMAREK, by instrument as recorded in Doc. No. 2021-010555 of the Official Records of said county, and being more particularly bounded and described, as follows:

Being a parcel of land lying on the left side of the existing centerline of TR158 (Stephens Road) as shown on the "WAR-TR158-0.92 (Stephens Road) Centerline Plat" part of the Right of Way plans for WAR-TR158-0.92 (Stephens Road) on file in the Warren County Engineer's Office:

Beginning for reference at the southwest corner of said 5.067-acre tract, said corner being at centerline station 49+42.12;

Thence with the west line of said 5.067-acre tract North 10° 38' 19" East 20.05 feet to a point in the existing north right of way line for TR158 (Stephens Road) (40'), 20.00 feet left of centerline station 49+43.49;

Thence with said line South 83° 17' 26" East 141.51 feet to a point in the new north right of way line of TR158, 20.00 feet left of centerline Station 50+85.00, being the TRUE POINT OF BEGINNING;

PARCEL 3-T2

Thence with said new north right of way line North 06° 42' 34" East 35.00 feet to a point 55.00 feet left of centerline Station 50+85.00;

Thence continuing with said new north right of way line North 83° 17' 26" West 77.00 feet to a point 55.00 feet left of centerline Station 50+08.00;

PARCEL 3-T2 cont'd

Thence along new lines through said tract for the following six courses:

1. North 63° 20' 42" East 12.28 feet to a point 61.75 feet left of centerline Station 50+18.25;

2. North 80° 10' 47" East 57.11 feet to a point 78.00 feet left of centerline Station 50+73.00;

3. South 26° 07' 08" East 36.89 feet to a point 47.00 feet left of centerline Station 50+93.00;

4. South 56° 43' 32" East 20.12 feet to a point 38.00 feet left of centerline Station 51+11.00;

5. South 73° 58' 50" East 61.81 feet to a point 28.00 feet left of centerline Station 51+72.00;

6. South 81° 46' 59" East 32.51 feet to a point in new north right of way line of TR158, 27.14 feet left of centerline Station 52+04.50;

   Thence with said new north right of way line South 06° 42' 34" West 7.14 feet to a point in the existing north right of way line of TR158, 20.00 feet left of centerline Station 52+04.50;

   Thence with said line North 83° 17' 26" West 119.50 feet to the TRUE POINT OF BEGINNING, containing 0.0625 acres, (2723 SF), more or less, and subject to all legal easements and restrictions of record.

This description is based upon a field survey performed by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548, in April 2023, with bearings based upon the Ohio State Plane Coordinates, South Zone, NAD83 (2011), by GPS utilizing ODOT VRS, and conventional surveying.

This description was prepared by LJB Inc. under the direction of David A. Hulsmeyer, Registered Surveyor Number 8548. The survey record of which is filed in Vol. 159, Plat 10 of the Warren County Engineer's record of land surveys.

EXHIBIT A

LPA RX 887 T

Rev. 07/09

PARCEL 3-T2 cont'd

Monument Boxes referred to as "set" are Centerline Monument Box assemblies to be set during construction, containing a 1" Iron pin to be set by the contractor's registered surveyor.

Evidence of occupation supports the monumentation found in the field and the property lines recited in this description.

Grantor claims title through instrument of record in Doc. No. 2021-010555, Warren County Recorder's Office.

0.0625 acres of the above-described area is contained within Warren County Auditor's Parcel Number 17-34-200-054, of which the present road right of way occupies 0.0000 acres, more or less.

Prepared by
LJB Inc.

By: David A. Hulsmeyer 9/27/23
David A. Hulsmeyer, Ohio PS No. 8548 Date

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0253 *Adopted Date* February 20, 2024

AUTHORIZING THE PRESIDENT OF THE BOARD TO SIGN A SUBGRANT AWARD AGREEMENT ON BEHALF OF THE GREATER WARREN COUNTY DRUG TASK FORCE

BE IT RESOLVED, to authorize the President of the Board to sign a Subgrant Award Agreement, on behalf of the Greater Warren County Drug Task Force for the Fiscal Year 2023 Edward Byrne Memorial Justice Assistance Grant, Subgrant Number 2023-JG-A01-6252, as attached hereto and made a part hereof, being funded through the U.S. Department of Justice Bureau of Justice Assistance, with the Ohio Office of Criminal Justice Services as the duly authorized State Agency; and

BE IT FURTHER RESOLVED, in the event funding is not available from the State of Ohio Office of Criminal Justice Services, the Warren County Board of Commissioners has no further obligation to fund this project.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

sm\

cc: c/a – Ohio Office of Criminal Justice Services
OGA
Drug Task Force (file)
Auditor's Office – Brenda Quillen

Ohio | Department of Public Safety

OCJS
Office of Criminal Justice Services

Mike DeWine, Governor
Jon Husted, Lt. Governor

Andy Wilson, Director
Nicole M. Dehner, Executive Director

SUBGRANT AWARD AGREEMENT

Subgrant Number: 2023-JG-A01-6252

Title: Greater Warren County Drug Task Force

In accordance with the provisions of the Consolidated Appropriations Act, FY 2005, Public Law 108-447; 118 Stat. 2862, Catalog of Federal Domestic Assistance (CFDA) 16.738 Edward Byrne Memorial Justice Assistance Grant 2023 funded through the U.S. Department of Justice Bureau of Justice Assistance, the Ohio Office of Criminal Justice Services, as the duly authorized State Agency, hereby approves the project application submitted as complying with the requirements of the Agency for the fiscal year indicated in the subgrant number above and awards to the foregoing Subgrantee a Subgrant as follows:

Subgrantee:	Warren County Commissioners		
Implementing Agency:	Greater Warren County Drug Task Force		
Award Periods:	01/01/2024 to 12/31/2024		
Closeout Deadline:	03/01/2025		
Award Amounts:	OCJS Funds:	$50,734.77	75%
	Cash Match:	$16,911.59	25%
	Inkind Match:	$0.00	
	Project Total:	$67,646.36	100%

The terms set forth in the 'Responsibility for Claims' section of the OCJS Standard Federal Subgrant Conditions Handbook are subject to Ohio law, including section 3345.15 of the Ohio Revised Code and the Ohio Constitution. As a result, those terms may not apply to subgrant recipients who are political subdivisions of the state, and do not apply to state instrumentalities.

This Subgrant is subject to the statements as set forth in the approved Programmatic and Budget Application submitted and approved revisions thereto, as well as the OCJS Standard Federal Subgrant Conditions and Special Conditions to this Subgrant, which are attached hereto and hereby included by reference herein. The Subgrant is also bound by all applicable federal guidelines, as referenced in the Standard Conditions. Revisions to this Subgrant Award Agreement must be approved in writing by OCJS.

The Subgrant shall become effective as of the award date, for the period indicated, upon return to OCJS of this Subgrant Award Agreement executed on the behalf of the Subgrantee's and Implementing Agency's authorized official in the space provided below.

Nicole Dehner

Nicole M. Dehner, Executive Director
Ohio Office of Criminal Justice Services

2.7.2024

Award Date

The Subgrantee agrees to serve as the official subrecipient of the award, agrees to provide the required match as indicated above, and assumes overall responsibility for compliance with the terms and conditions of the award. I hereby accept this Subgrant on behalf of the Subgrantee.

County Commissioner - President — Date: 2-20-24
Warren County Commissioners

The Implementing Agency agrees to comply with the terms and conditions of the award. I hereby accept this Subgrant on behalf of the Implementing Agency.

Major S. Quaglett — Date: 2/14/24
Major/Commander
Greater Warren County Drug Task Force

APPROVED AS TO FORM

Derek B. Faulkner
Asst. Prosecuting Attorney

Mission Statement

"to save lives, reduce injuries and economic loss, to administer Ohio's motor vehicle laws and to preserve the safety and well being of all citizens with the most cost-effective and service-oriented methods available."

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0254 *Adopted Date* February 20, 2024

ACKNOWLEDGING PAYMENT OF BILLS

BE IT RESOLVED, to acknowledge payment of bills from 2/13/24 and 2/15/24 as attached hereto and made a part hereof.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

/kp

cc: Auditor ___

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0255 *Adopted Date* February 20, 2024

APPROVING A SUBDIVISION PUBLIC IMPROVEMENT PERFORMANCE AND MAINTENANCE SECURITY BOND REDUCTION WITH GRAND COMMUNITIES, LLC. FOR COMPLETION OF WATER AND SEWER IMPROVEMENTS IN THE MAJORS AT SHAKER RUN SUBDIVISION, SECTION TWO, SITUATED IN TURTLECREEK TOWNSHIP

BE IT RESOLVED, upon recommendation of the Warren County Sanitary Engineer, to approve the following security reduction:

SECURITY REDUCTION

Bond Number	:	23-013 (W/S)
Development	:	Majors at Shaker Run, Section Two
Developer	:	Grand Communities, LLC.
Township	:	Turtlecreek
Original Amount	:	$189,139.60
Reduction Amount	:	$174,590.40
Surety Company	:	RLI Insurance Company (CMS0354815)

BE IT FURTHER RESOLVED, the original amount of bond was $189,139.60 and the new required bond amount is $14,549.20.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

caw

cc: Grand Communities, Ltd., Randy Acklin, 3940 Olympic Blvd, Suite 100, Erlanger KY 41018
RLI Insurance Company, 9025 N. Lindbergh Drive, Peoria, Il 61615
Water/Sewer (file)
Bond Agreement file

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0256 *Adopted Date* February 20, 2024

ACCEPTING AN AMENDED CERTIFICATE AND APPROVING AN APPROPRIATION DECREASE AND SUPPLEMENTAL APPROPRIATION FOR THE MIAMI VALLEY GAMING TIF FUND #4485

WHEREAS, in order for the Warren County Commissioner's Office to be able to encumber funds for the Miami Valley Gaming Racino, an amended certificate needs to be accepted and an appropriation decrease, and a supplemental appropriation need to be approved.

NOW THEREFORE BE IT RESOLVED, to accept an amended certificate from the Budget Commission in the amount of $792,480.00 for the Miami Valley Gaming TIF fund 4485:and

BE IT FURTHER RESOLVED, approve the following appropriation decrease and supplemental appropriation for the Miami Valley Gaming TIF Fund #4485:

Appropriation Decrease

$100,000.00 from 44853120-5750 (Distribution of Funds)

Supplemental Appropriation

$816,282.00 into 44853120-5910 (Other Expenses)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Amended Certificate file
Appropriation Dec. file
Supplemental App. file
Economic Development (file)
OMB

AMENDED OFFICIAL CERTIFICATE OF ESTIMATED RESOURCES

Rev. Code, Sec 5705.36

Office of Budget Commission, County of Warren, Lebanon, Ohio, February 13, 2024

To the TAXING AUTHORITY of Warren County Commissioners

The following is the amended certificate of estimated resources for the fiscal year beginning January 1st, 2024, as revised by the Budget Commission of said county, which shall govern the total of appropriations made at any time during such fiscal year.

FUND TYPE - Capital Projects	Jan. 1st, 2024	Taxes	Other Sources	Total
Miami Valley Gaming TIF	$968,317.23		$1,096,000.00	$2,064,317.23
Fund ~~4460~~ 4485				
TOTAL	$968,317.23	$0.00	$1,096,000.00	$2,064,317.23

Matt Nolan

Budget Commission

AMEND 24 05
4485 40150 +792,840.00

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0257 *Adopted Date* February 20, 2024

APPROVING A CASH ADVANCE FROM THE COUNTY MOTOR VEHICLE FUND #2202 INTO THE MCCLURE ROAD BRIDGE #71-0.39 REHABILITATION PROJECT FUND #4460

WHEREAS, Neil Tunison, Warren County Engineer, and appointing authority for the McClure Road Bridge #71-0.39 Project has requested a cash advance until monies are received from fund #2202; and

WHEREAS, said cash advance will be repaid upon receipt of said funds from fund #2202.

NOW THEREFORE BE IT RESOLVED, to approve the following cash advance:

$35,000.00	from	2202-45556	(Advances of Cash Out)
	into	4460-45555	(Cash Advance In)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Cash Advance File
Engineer (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0258 *Adopted Date* February 20, 2024

APPROVING OPERATIONAL TRANSFER FROM COMMISSIONERS FUND #11011112 INTO HUMAN SERVICES FUND #2203

WHEREAS, the Department of Human Services has requested that the seventh and eighth monthly disbursement of their mandated share for SFY 2023-2024 be transferred into the Human Services Public Assistance Fund #2203: and

NOW THEREFORE BE IT RESOLVED, to approve the following operational transfer from Commissioner Fund #1101 to Human Services Fund #2203:

$34,334.00	from	#11011112-5742	(Commissioners Grants – Public Assistance)
	into	#2203-49000	(Human Services – Public Assistance)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Operational Transfer file
Human Services (file)
OMB

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0259 *Adopted Date* February 20, 2024

APPROVING SUPPLEMENTAL APPROPRIATIONS INTO THE CLERK OF COURT'S GENERAL FUNDS #11011260 AND #11011282

BE IT RESOLVED, to approve the following supplemental appropriations:

$ 2,985.71	into	#11011260-5830	(Workers Compensation)
$ 1,871.61	into	#11011282-5830	(Workers Compensation)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Supplemental App. file
Clerk of Courts (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0260 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN COMMISSIONERS FUND #11011110

BE IT RESOLVED, to approve the following appropriation adjustment in order to process the Workers Comp Chargeback:

$7,000.00	from	#11011110-5210	(Genl BOCC Materials & Supplies)
	into	#11011110-5830	(Genl BOCC Workers Comp)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
OMB (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0261 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN COMMON PLEAS COURT FUND #11011220

BE IT RESOLVED, to approve the following appropriation adjustment:

$3,200.00	from	11011220-5820	(Health/Life Insurance)
	into	11011220-5830	(Workers Compensation)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
Common Pleas Court (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0262 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN COMMON PLEAS COURT FUND #11011223

BE IT RESOLVED, to approve the following appropriation adjustment:

$9,500.00	from	11011223-5820	(Health/Life Insurance)
	into	11011223-5830	(Workers Compensation)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
Common Pleas Court (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0263 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN JUVENILE COURT FUND #10111240

BE IT RESOLVED, to approve the following appropriation adjustment within Juvenile Court fund #11011240:

$ 30,000.00	from	11011240-5415	(JUV CT Attorney-Indigent)
	into	11011240-5910	(JUV CT Other Expense)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor___
Appropriation Adj. file
Juvenile (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0264 *Adopted Date* February 20, 2024

APPROVING APPROPRIATION ADJUSTMENTS WITHIN NOTARY PUBLIC FUND #11011292

BE IT RESOLVED, to approve the following appropriation adjustments:

$600.00	from	#11011292-5210	(Notary Material & Supplies)
	into	#11011292-5820	(Health & Life Insurance)
$600.00	from	#11011292-5210	(Notary Material & Supplies)
	into	#11011292-5317	(Non Capital Purchase)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adj. file
Law Library (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0265 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN BOARD OF ELECTIONS FUND #11011300

BE IT RESOLVED, to approve the following appropriation adjustment:

$2,659.27	from	#11011300-5102	(Regular Salaries)
	into	#11011300-5830	(Workers Compensation)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adj. file
Board of Elections (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0266 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT FROM COMMISSIONERS GENERAL FUND #11011110 INTO SHERIFF'S OFFICE FUND #11012210

BE IT RESOLVED, to approve the following appropriation adjustment from Commissioners Fund #11011110 into Sheriff's Office Fund #11012210 in order to process a vacation leave payout for Trevor McCracken, former employee of Sheriff's Office - Corrections:

$3,510.00	from	#11011110-5882	(Commissioners – Vacation Leave Payout)
	into	#11012210-5882	(Sheriff's Office –Vacation Leave Payout)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
Sheriff (file)
OMB

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0267 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT FROM JUVENILE FUND 11012600 INTO 11012500

BE IT RESOLVED, to approve the following appropriation adjustment in order to correct vacation leave payout distribution:

$2,358.00	from	#11012600-5882	(Genl Juv Det Vacation Leave Payout)
	into	#11012500-5882	(Genl Juv Prob Vacation Leave Payout)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
Juvenile (file)
OMB

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0268 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT FROM COMMISSIONERS GENERAL FUND #11011110 INTO JUVENILE DETENTION FUND #11012600

BE IT RESOLVED, to approve the following appropriation adjustment from Commissioners Fund #11011110 into Juvenile Detention Fund #11012600 in order to process a vacation leave payout for Cryztopher Norris, former employee of the Juvenile Detention Center:

$2,143.00	from	#11011110-5882	(Genl BOCC – Vacation Leave Payout)
	into	#11012600-5882	(Juv Det – Vacation Leave Payout)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
Juvenile (file)
OMB

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0269 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN JUVENILE DETENTION FUND #11012600

BE IT RESOLVED, to approve the following appropriation adjustment within Juvenile Detention fund #11012600:

$ 23,023.00	from	11012600-5114	(Juv Det Overtime Pay)
	into	11012600-5830	(Juv Det Workers Compensation)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adj. file
Juvenile (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0270 *Adopted Date* February 20, 2024

APPROVE APPROPRIATION ADJUSTMENTS WITHIN ENGINEER'S OFFICE FUND #2202

BE IT RESOLVED, to approve the following appropriation adjustments for payroll:

$ 500.00	from	22023110-5210	(Materials and Supplies)
	into	22023110-5911	(Non Taxable Meal Fringe)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adj. file
Engineer (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0271 *Adopted Date* February 20, 2024

APPROVING APPROPRIATION ADJUSTMENT WITHIN JUVENILE COURT FUND #2247

BE IT RESOLVED, to approve the following appropriation adjustment within Juvenile Court RECLAIM fund #2247:

$2,000.00	from	22471242-5400	(Purchased Services)
	into	22471242-5910	(Other Expense)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adj. file
Juvenile (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0272 *Adopted Date* February 20, 2024

APPROVING APPROPRIATION ADJUSTMENTS WITHIN THE OHIOMEANSJOBS WARREN COUNTY FUND #2258

BE IT RESOLVED, to approve appropriation adjustments within the OhioMeansJobs Warren County Fund # 2258:

$ 20,000.00	from	22585800-5102	(Regular Salaries)
$ 5,000.00	from	22585800-5210	(Material & Supplies)
$ 20,000.00	from	22585800-5400	(Purchased Services)
$ 25,000.00	from	22585800-5421	(Rent or Lease)
$ 70,000.00	into	22585800-5663	(Classroom Training Adults)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

cc: Auditor ✓
Appropriation Adjustment file
OhioMeansJobs (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0273 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN CHILDREN SERVICES FUND #2273

BE IT RESOLVED, to approve the following appropriation adjustment:

$29,663.00	from	#22735100-5446	(Child Placement)
	into	#22735100-5447	(Child Placement Specialized)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

jc/

cc: Auditor ✓
Appropriation Adj. file
Children Services (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0274 *Adopted Date* February 20, 2024

APPROVING AN APPROPRIATION ADJUSTMENT WITHIN CHILDREN SERVICES FUND #2273

BE IT RESOLVED, to approve the following appropriation adjustment:

$2,037.02	from	#227351005102	(Regular Salaries)
	into	#227351005830	(Worker's Compensation)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

jc/

cc: Auditor ✓
Appropriation Adj. file
Children Services (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0275 *Adopted Date* February 20, 2024

APPROVING APPROPRIATION ADJUSTMENT WITHIN THE SEWER REVENUE FUND #5580

WHEREAS, the Water and Sewer Department incurs travel expenses for conferences and training to include mileage, hotel, airfare, and transportation; and

WHEREAS, an appropriation adjustment is necessary to accommodate said costs.

NOW THEREFORE BE IT RESOLVED, to approve the following appropriation adjustment:

$1,500.00	from	55803300 - 5998	(Reserve/Contingency)
	into	55803300 - 5940	(Travel)

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

mbz

cc: Auditor___
Appropriation Adj. file
Water/Sewer (file)

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0276 *Adopted Date* February 20, 2024

APPROVING REQUISITIONS AND AUTHORIZING COUNTY ADMINISTRATOR TO SIGN DOCUMENTS RELATIVE THERETO

BE IT RESOLVED, to approve requisitions as listed in the attached document and authorize Martin Russell, County Administrator, to sign on behalf of this Board of County Commissioners.

Mr. Grossmann moved for adoption of the foregoing resolution being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

/kp

cc:
Commissioners' file

REQUISITIONS

Department	Vendor Name	Description	Amount	
WAT	JEFF SCHMITT AUTO GROUP INC	WAT POLARIS RANGER XD 1500	$ 43,079.90	*capital purchase
ENG	STEVEN J KOMAREK & MARGO K KOMAREK	ENG.PERM AND TEMP EASE FOR STE	$ 6,643.00	*contract in packet
EMS	BIDDLE CONSULTING GROUP	EMS ONLINE TESTING	$ 5,725.00	*contract in packet

2/20/2024 APPROVED:

Martin Russell, County Administrator

BOARD OF COUNTY COMMISSIONERS
WARREN COUNTY, OHIO

Resolution

Number 24-0277 *Adopted Date* February 20, 2024

APPROVING THE REZONING APPLICATION OF THE SISTERS, LTD. (CASE #2023-10) TO REZONE APPROXIMATELY 2.0 +/- ACRES (BEING A PART OF PARCEL ID# 13-16-100-037) FROM LIGHT INDUSTRIAL MANUFACTURING ZONE "I1" WITH JEDD OVERLAY TO COMMUNITY COMMERCIAL BUSINESS ZONE "B2" WITHOUT JEDD OVERLAY IN TURTLECREEK TOWNSHIP

WHEREAS, after completing notice as required by Section 1.304.3 of the Warren County Rural Zoning Code, this Board met this 20th day of February 2024, to conduct the public hearing for the rezoning application of The Sisters, LTD, as owner of record (Case #2023-10), to rezone approximately 2.0 +/- acres (being a part of Parcel ID# 13-16-100-037 consisting of a total of 8.8983 acres more or less) located along Route 350 in Turtlecreek Township from Light Industrial Manufacturing Zone "I1" with JEDD Overlay to Community Commercial Business Zone "B2" without JEDD Overlay; and,

WHEREAS, this Board considered the Zoning Department's PowerPoint presentation during the hearing and the testimony of the applicant, the proponents and opponents, as well as the written recommendations of the Warren County RPC Executive Committee and the Warren County Rural Zoning Commission; and,

WHEREAS, on motion and call of the roll, the Board voted 2-0 to close the public for deliberations and to vote.

NOW THEREFORE BE IT RESOLVED, to approve the rezoning application of The Sisters, LTD, as owner of record (Case #2023-10), to rezone approximately 2.0 +/- acres (being a part of Parcel ID# 13-16-100-037), the approximate location of which as shown on the attached Site Plan, from Light Industrial Manufacturing Zone "I1" with JEDD Overlay to Community Commercial Business Zone "B2" without the JEDD Overlay in Turtlecreek Township.

Mr. Grossmann moved for adoption of the foregoing resolution, being seconded by Mr. Young. Upon call of the roll, the following vote resulted:

Mrs. Jones – absent
Mr. Young – yea
Mr. Grossmann – yea

Resolution adopted this 20th day of February 2024.

BOARD OF COUNTY COMMISSIONERS

Krystal Powell

Krystal Powell, Clerk

/kp

cc: RPC
RZC
Rezoning file
Applicant
Township Trustees

Total Site

- **Total Site:** 8.8963-acres
- **Subject Site:** 2-acres (Only the Subject Site would be rezoned)