2017 INSURANCE AGREEMENT

UNITEDHEALTHCARE INSURANCE COMPANY

THIS AGREEMENT to purchase insurance policies is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "City") and UnitedHealthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103-0450 (the "**Insurance Company,**" and jointly "the parties").

The parties agree as follows:

1. COORDINATION AND LIAISON: The Insurance Company shall fully coordinate the purchase of agreed policies with the Executive Director of the Office of Human Resources or the Executive Director's designee ("**Executive Director**").

a. The Executive Director, shall be authorized to sign the final insurance policies, and the attached Exhibits as needed, to effectuate the policy-related documents necessary for implementation or administration.

2. SERVICES TO BE PERFORMED:

a. The insurance policy being purchased by the City requires approval by the Colorado Division of Insurance ("DOI"). If the insurance policy is pending DOI approval, the Summary of Benefits and Coverage ("SBC"), and Performance Guarantees document (collectively attached hereto and incorporated herein as "**Exhibit A**") are attached as evidence of the insurance policy coverage the City intends to purchase.

b. Upon receipt of the DOI-approved Evidence of Coverage (or Certificate of Coverage) the Executive Director shall file the DOI-approved insurance policy and Evidence of Coverage with the City's Clerk and Recorder to complete the public record for this Agreement.

c. Insurance Company will provide the City with all internal policies which affect coverage under this Agreement. These policies will be disclosed to the City prior to the effective date of this Agreement.

3. TERM: This Agreement and the underlying insurance policies shall be effective January 1, 2017 ("Effective Date"), and will expire December 31, 2017 (the "Term"). The insurance policies listed in **Exhibit A** shall expire at the end of the Term.

4. COMPENSATION AND PAYMENT:

a. Fee: The City shall pay, and the Insurance Company shall accept as the sole compensation, the Maximum Contract Amount in monthly payments as required in the policies attached in **Exhibit A**, as full payment for the policies. Notwithstanding any other provision, if a policy is cancelled by the City prior to the end of the Term, the City shall be responsible to pay all pro rata amounts due through the end of the calendar month of termination.

b. Reimbursable Expenses: There are no reimbursable expenses allowed under this Agreement. Notwithstanding any term in the policy to the contrary and outside of the policy premium costs, the Insurance Company will not collect or attempt to collect any direct cost associated with the policies purchased by the City. Further, the Insurance Company agrees not to adjust the policy premiums at any time prior to the termination of this Agreement.

c. Maximum Contract Amount:

(1) Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed **SIXTY FIVE MILLION THREE HUNDRED SIXTEEN THOUSAND ONE HUNDRED THIRTY FOUR AND 40/100 dollars ($65,316,134.40**) (the "**Maximum Contract Amount**") for the policies listed in **Exhibit A**. The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Insurance Company beyond that specifically described in **Exhibit A**. Any services performed beyond those in **Exhibit A** are performed at Insurance Company's risk and without authorization under this Agreement.

(2) The City's payment obligation, whether direct or contingent, extends only to funds appropriated annually by the Denver City Council, paid into the Treasury of the City, and encumbered for the purpose of the Agreement. The City does not by this Agreement irrevocably pledge present cash reserves for payment or performance in future fiscal years. The Agreement does not and is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

d. Wellness Platform Software Payment: The parties agree that the City needs to implement a wellness platform software to support the City employee wellness effort and successfully administer the City's wellness program through the use of centralized wellness data. For that reason, Insurance Company agrees to pay $200,000 to the workplace wellness software provider Viverae, Inc., for the purchase and implementation of a wellness platform

software that the City will maintain. Said workplace wellness software provider Viverae, Inc. is the City's vendor and will have an executed contract with the City. Such payment will be paid in full to Viverae, Inc. no more than 30 days after invoicing. Insurance Company agrees that the wellness platform software payment will not reduce the "funds" or "credits" used toward Wellness Programs, as defined herein, and further, the wellness platform software payment will not be funded through increased City insurance premiums, as described in Exhibit A.

5. STATUS OF INSURANCE COMPANY: The Insurance Company is an independent contractor. Neither the Insurance Company nor any of its employees are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code, or for any purpose whatsoever.

6. TERMINATION:

a. The City has the right to terminate this Agreement and any policy listed in **Exhibit A**, or all policies, with or without cause upon thirty (30) days prior written notice to the Insurance Company or under the terms of the policies as referenced in **Exhibit A**.

b. Upon termination the Insurance Company shall have no claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation due under a policy for the month of termination.

7. EXAMINATION OF RECORDS: Any authorized agent of the City, including the City Auditor or his or her representative, has the right to reasonable access and the right to examine any pertinent books, documents, papers and records of the Insurance Company, involving transactions related to the Agreement, during reasonable hours and until the latter of three (3) years after the final payment under the Agreement or expiration of the applicable statute of limitations. Nothing in this provision shall require the Insurance Company to make disclosures in violation of state or federal privacy laws.

8. WHEN RIGHTS AND REMEDIES NOT WAIVED: In no event will any payment or other action by the City constitute or be construed to be a waiver by the City of any breach of covenant or default that may then exist on the part of the Insurance Company. No payment, other action, or inaction by the City when any breach or default exists will impair or prejudice any right or remedy available to it with respect to any breach or default. No assent, expressed or implied, to any breach of any term of the Agreement constitutes a waiver of any other breach.

9. INSURANCE:

a. General Conditions: Insurance Company agrees to secure, at or before the time of execution of this Agreement, the following insurance covering all operations, goods or services provided pursuant to this Agreement. Insurance Company shall keep the required insurance coverage in force at all times during the term of the Agreement, or any extension thereof, during any warranty period, and for three (3) years after termination of the Agreement. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-"VIII or better. Each policy shall contain a valid provision or endorsement requiring notification to the City in the event any of the above-described policies are canceled before the expiration date thereof. Such written notice shall be sent to the parties identified in the Notices section of this Agreement and shall reference the City contract number listed on the signature page of this Agreement. Said notice shall be sent thirty (30) days prior to such cancellation unless due to non- payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer, Insurance Company shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section within three (3) business days of such notice by its insurer(s) and referencing the City's contract number. Insurance Company shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Insurance Company. The Insurance Company shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

b. Proof of Insurance: Insurance Company may not commence services or work relating to the Agreement prior to placement of coverages required under this Agreement. Insurance Company certifies that the certificate of liability insurance, attached as **Exhibit B**, preferably an ACORD certificate, complies with all insurance requirements of this Agreement. The City requests that the City's contract number be referenced on the Certificate. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Insurance Company's breach of this Agreement or of any of the City's rights or remedies under this Agreement.

c. **Waiver of Subrogation**: For all coverages, except the professional and technology E &O, Insurance Company's insurer shall waive subrogation rights against the City.

d. **Workers' Compensation/Employer's Liability Insurance**: Insurance Company shall maintain the coverage as required by statute for each work location and shall maintain Employer's Liability insurance with limits of $100,000 per occurrence for each bodily injury claim, $100,000 per occurrence for each bodily injury caused by disease claim, and $500,000 aggregate for all bodily injuries caused by disease claims. Insurance Company expressly represents to the City, as a material representation upon which the City is relying in entering into this Agreement, that none of the Insurance Company's officers or employees who may be eligible under any statute or law to reject Workers' Compensation Insurance shall effect such rejection during any part of the term of this Agreement, and that any such rejections previously effected, have been revoked as of the date Insurance Company executes this Agreement.

e. **Commercial General Liability**: Insurance Company shall maintain a Commercial General Liability insurance policy with limits of $1,000,000 for each occurrence, $1,000,000 for each personal and advertising injury claim, $2,000,000 products and completed operations aggregate, and $2,000,000 policy aggregate.

f. **Business Automobile Liability**: Insurance Company shall maintain Business Automobile Liability with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement.

g. **Professional Liability (Errors & Omissions)**: Insurance Company shall maintain limits of $1,000,000 per claim and $1,000,000 policy aggregate limit.

h. **Cyber Liability:** Contractor shall maintain Cyber Liability coverage with limits of $1,000,000 per occurrence and $1,000,000 policy aggregate covering third party claims involving privacy violations, information theft, and intentional and/or unintentional release of private information.

10. DEFENSE AND INDEMNIFICATION

a. To the fullest extent permitted by law, Insurance Company hereby agrees to defend, indemnify, reimburse and hold harmless City, its appointed and elected officials, agents and employees for, from and against all liabilities, claims, judgments, suits or demands

for damages to persons or property arising out of, resulting from, or related to the work performed under this Agreement that are due to the negligence or fault of Insurance Company or Insurance Company's agents, representatives, subcontractors, or suppliers ("**Claims**"). This indemnity shall be interpreted in the broadest possible manner consistent with the applicable law to indemnify the City.

b. Insurance Company's duty to defend and indemnify City shall arise at the time written notice of the Claim is first provided to City regardless of whether suit has been filed and even if Insurance Company is not named as a Defendant.

c. Insurance Company will defend any and all Claims which may be brought or threatened against City and will pay on behalf of City any expenses incurred by reason of such Claims including, but not limited to, court costs and attorney fees incurred in defending and investigating such Claims or seeking to enforce this indemnity obligation. Such payments on behalf of City shall be in addition to any other legal remedies available to City and shall not be considered City's exclusive remedy.

d. Insurance coverage requirements specified in this Agreement shall in no way lessen or limit the liability of the Insurance Company under the terms of this indemnification obligation. Insurance Company shall obtain, at its own expense, any additional insurance that it deems necessary for the City's protection.

e. This defense and indemnification obligation shall survive the expiration or termination of this Agreement.

11. TAXES, CHARGES AND PENALTIES: The City is not liable for the payment of taxes, late charges or penalties of any nature, except for any additional amounts that the City may be required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, *et seq*. The Insurance Company shall promptly pay when due, all taxes, bills, debts and obligations it incurs performing the services under the Agreement and shall not allow any lien, mortgage, judgment or execution to be filed against City property.

12. ASSIGNMENT; SUBCONTRACTING: Except as provided in this provision, the Insurance Company shall not voluntarily or involuntarily assign any of its rights or obligations, or subcontract performance obligations, under this Agreement without obtaining the Executive Director's prior written consent. That consent will not be unreasonably withheld. Nevertheless, Insurance Company can assign this Agreement, including its rights and obligations

to Insurance Company's affiliates, to an entity controlling, controlled by, or under common control with Insurance Company, or a purchase of all or substantially all of Insurance Company's assets, subject to notice to the City of the assignments. Any assignment or subcontracting without such consent will be ineffective and void, and will be cause for termination of this Agreement by the City. The Executive Director has sole and absolute discretion whether to consent to any assignment or subcontracting, or to terminate the Agreement because of unauthorized assignment or subcontracting. In the event of any subcontracting or unauthorized assignment: (i) the Insurance Company shall remain responsible to the City; and (ii) no contractual relationship shall be created between the City and any sub- Insurance Company, subcontractor or assign.

13. INUREMENT: The rights and obligations of the parties to the Agreement inure to the benefit of and shall be binding upon the parties and their respective successors and assigns, provided assignments are consented to in accordance with the terms of the Agreement.

14. NO THIRD PARTY BENEFICIARY: Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the City or the Insurance Company receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

15. GRANT OF LIMITED LICENSE TO USE LOGO

a. City hereby grants to Insurance Company, subject to the terms and conditions set forth herein, a non-exclusive, nontransferable limited license, to use the "Denver D" logo ("**Denver Logo**") during the Term of this Agreement.

b. Insurance Company shall fully coordinate all logo use under this Agreement with the Denver Marketing Office ((720) 913-1633, denvermarketingoffice@denvergov.org), or otherwise as directed by the City.

c. The use of the Denver Logo is limited to display on the website to be created by Insurance Company pursuant to this Agreement and for the purpose of identification only. Insurance Company shall display the Denver Logo in a read-only format and shall not be used or displayed on the website in any format from which it can be downloaded, copied or reproduced in any manner.

d. The license granted by the City is non-transferable and non-assignable to anyone other than those acting under the supervision and authority of Insurance Company.

e. Insurance Company shall be solely responsible for the entire cost and expense of Insurance Company's Use of the Denver Logo.

f. The Denver Logo may not be used as a feature or design element of any other logo or graphic.

g. Insurance Company shall use the Denver Logo in accordance with any and all logo usage guidelines in effect from time-to-time as provided by the City. Insurance Company shall use only accurate reproductions of the Denver Logo. The size, proportions, colors, elements, and other distinctive characteristics of the Denver Logo shall not be altered in any manner except as may be permitted herein or as permitted in writing by the City.

h. Insurance Company may use the colors set forth in the "Denver Logo Guidelines" document, (attached hereto as "**Exhibit C**").

i. Insurance Company shall affix a trademark ("™") or registration ("®") indication next to the Denver Logo as directed by the Denver Marketing Office.

j. Insurance Company shall immediately cease all use of the Denver Logo upon expiration of the Term of this Agreement, as may have been extended from time to time by the parties, in a formal written extension of this agreement.

16. NO AUTHORITY TO BIND CITY TO CONTRACTS: The Insurance Company lacks any authority to bind the City on any contractual matters. Final approval of all contractual matters that purport to obligate the City must be executed by the City in accordance with the City's Charter and the Denver Revised Municipal Code.

17. SEVERABILITY: Except for the provisions of the Agreement requiring appropriation of funds and limiting the total amount payable by the City, if a court of competent jurisdiction finds any provision of the Agreement or any portion of it to be invalid, illegal, or unenforceable, the validity of the remaining portions or provisions will not be affected, if the intent of the parties can be fulfilled.

18. CONFLICT OF INTEREST:

a. No employee of the City shall have any personal or beneficial interest in the services or property described in the Agreement. The Insurance Company shall not hire, or

contract for services with, any employee or officer of the City that would be in violation of the City's Code of Ethics, D.R.M.C. §2-51, et seq. or the Charter §§ 1.2.8, 1.2.9, and 1.2.12.

b. The Insurance Company shall not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement. The Insurance Company represents that it has disclosed any and all current or potential conflicts of interest. A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of the Insurance Company by placing the Insurance Company's own interests, or the interests of any party with whom the Insurance Company has a contractual arrangement, in conflict with those of the City. The City, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement if it determines a conflict exists, after it has given the Insurance Company written notice describing the conflict.

19. NOTICES: Policy restrictions notwithstanding, all notices required by the terms of the Agreement must be hand delivered, sent by overnight courier service, mailed by certified mail, return receipt requested, or mailed via United States mail, postage prepaid, if to Insurance Company at the address first above written, and if to the City at:

Executive Director
Office Human Resources
201 West Colfax Avenue, Dept. 412
Denver, Colorado 80202

With a copy of any such notice to:

Denver City Attorney's Office
1437 Bannock St., Room 353
Denver, Colorado 80202

Notices hand delivered or sent by overnight courier are effective upon delivery. Notices sent by certified mail are effective upon receipt. Notices sent by mail are effective upon deposit with the U.S. Postal Service. The parties may designate substitute addresses where or persons to whom notices are to be mailed or delivered. However, these substitutions will not become effective until actual receipt of written notification.

20. NO EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT:

a. This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance").

b. The Insurance Company certifies that:

(1) At the time of its execution of this Agreement, it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement.

(2) It will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.

c. The Insurance Company also agrees and represents that:

(1) It shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(2) It shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Insurance Company that it shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(3) It has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement, through participation in either the E-Verify Program.

(4) It is prohibited from using either the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under the Agreement, and it is required to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

(5) If it obtains actual knowledge that a subconsultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal alien, it will notify such subconsultant or subcontractor and the City within three (3) days. The Insurance Company shall also terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with an illegal alien.

(6) It will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S., or the City Auditor, under authority of D.R.M.C. 20-90.3.

d. The Insurance Company is liable for any violations as provided in the Certification Ordinance. If Insurance Company violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of the Agreement. If the Agreement is so terminated, the Insurance Company shall be liable for actual and consequential damages to the City. Any such termination of a contract due to a violation of this section or the Certification Ordinance may also, at the discretion of the City, constitute grounds for disqualifying Insurance Company from submitting bids or proposals for future contracts with the City.

21. DISPUTES. Parties agree that Section 6.2 of the Policy entitled "Dispute Resolution" shall not be binding on the City. In the event of dispute, the complaining party will notify the other party in writing. The parties will both make efforts to resolve the complaint. If the complaint is not resolved within 30 days of the notice of complaint, the complaining party is free to begin litigation of the issue in any appropriate venue.

22. GOVERNING LAW; VENUE: The Agreement will be construed and enforced in accordance with applicable federal law, the laws of the State of Colorado, and the applicable Charter, Revised Municipal Code, ordinances, regulations and Executive Orders of the City and County of Denver, which are expressly incorporated into the Agreement. Unless otherwise specified, any reference to statutes, laws, regulations, charter or code provisions, ordinances, executive orders, or related memoranda, includes amendments or supplements to same. Venue for any legal action relating to the Agreement will be in the District Court of the State of Colorado, Second Judicial District (Denver District Court).

23. NO DISCRIMINATION IN EMPLOYMENT: In connection with the performance of work under the Agreement, the Insurance Company may not refuse to hire, discharge, promote or demote, or discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, gender variance, marital status, or physical or mental disability. The Insurance Company shall insert similar foregoing provision in all subcontracts.

24. COMPLIANCE WITH ALL LAWS: Insurance Company shall perform or cause to be performed all services, both in this Agreement and pursuant to any insurance policies referenced in **Exhibit A**, in full compliance with all applicable laws, rules, regulations and codes of the United States, the State of Colorado; and with the applicable Charter, ordinances, rules,

regulations and Executive Orders of the City and County of Denver.

25. LEGAL AUTHORITY: Insurance Company represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Insurance Company represents and warrants that he has been fully authorized by Insurance Company to execute the Agreement on behalf of Insurance Company and to validly and legally bind Insurance Company to all the terms, performances and provisions of the Agreement. The City shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a dispute as to the legal authority of either Insurance Company or the person signing the Agreement to enter into the Agreement.

26. NO CONSTRUCTION AGAINST DRAFTING PARTY: The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because any provisions of the Agreement were prepared by a particular party.

27. ORDER OF PRECEDENCE: In the event of any conflicts between the language of the Agreement and the exhibits, the language of the Agreement controls, unless such language of the Agreement is severed because it was held to be invalid, illegal, or unenforceable in any respect.

28. SURVIVAL OF CERTAIN PROVISIONS: The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Insurance Company's obligations to provide insurance and to indemnify the City will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

29. ADVERTISING AND PUBLIC DISCLOSURE: The Insurance Company shall not include any reference to the Agreement or to services performed pursuant to the Agreement in any of the Insurance Company's advertising or public relations materials without first obtaining the written approval of the Executive Director. Any oral presentation or written materials related to services performed under the Agreement will be limited to services that have been accepted by the City. The Insurance Company shall notify the Executive Director in

advance of the date and time of any presentation. Nothing in this provision precludes the transmittal of any information to City officials.

30. CONFIDENTIAL INFORMATION:

a. City Information: Insurance Company acknowledges and accepts that, in performance of all work under the terms of this Agreement, Insurance Company may have access to Proprietary Data or confidential information that may be owned or controlled by the City, and that the disclosure of such Proprietary Data or information may be damaging to the City or third parties. Insurance Company agrees that all Proprietary Data, confidential information or any other data or information provided or otherwise disclosed by the City to Insurance Company shall be held in confidence and used only in the performance of its obligations under this Agreement. Insurance Company shall exercise the same standard of care to protect such Proprietary Data and information as a reasonably prudent Insurance Company would to protect its own proprietary or confidential data. "Proprietary Data" shall mean any materials or information which may be designated or marked "Proprietary" or "Confidential", or which would not be documents subject to disclosure pursuant to the Colorado Open Records Act or City ordinance, and provided or made available to Insurance Company by the City. Such Proprietary Data may be in hardcopy, printed, digital or electronic format.

31. CITY EXECUTION OF AGREEMENT: The Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

32. AGREEMENT AS COMPLETE INTEGRATION AMENDMENTS:The Agreement is the complete integration of all understandings between the parties as to the subject matter of the Agreement. No prior, contemporaneous or subsequent addition, deletion, or other modification has any force or effect, unless embodied in the Agreement in writing. No oral representation by any officer or employee of the City at variance with the terms of the Agreement or any written amendment to the Agreement will have any force or effect or bind the City.

33. USE, POSSESSION OR SALE OF ALCOHOL OR DRUGS: Insurance Company shall cooperate and comply with the provisions of Executive Order 94 and its Attachment A concerning the use, possession or sale of alcohol or drugs.

34. ELECTRONIC SIGNATURES AND ELECTRONIC RECORDS: Insurance

Company consents to the use of electronic signatures by the City. The Agreement, and any other documents requiring a signature under the Agreement, may be signed electronically by the City in the manner specified by the City. The parties agree not to deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

Exhibit List:
Exhibit A – Summary of Benefits and Coverage & Performance Guarantees
Exhibit B – Proof of Insurance
Exhibit C – Denver Logo Guidelines

[NOTE: SIGNATURE PAGES TO FOLLOW]

Contract Control Number:

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of

SEAL

CITY AND COUNTY OF DENVER

ATTEST:

By_____

_____

APPROVED AS TO FORM:

REGISTERED AND COUNTERSIGNED:

By_____

By_____

By_____

Contract Control Number: CSAHR-201631060-00

Contractor Name: UnitedHealthcare

By: _____

Name: Elizabeth Soberg Prokocki
(please print)

Title: President & CEO
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A

Summary of Benefits and Coverage & Performance Guarantees

UnitedHealthcare®

HSA Choice Plus Plan AGGW / 02V Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** PS1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-866-633-2446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,350** *Individual / **$2,700** Family Non-Network: **$3,000** *Individual / **$6,000** Family Per calendar year. Services listed below as "No Charge" do not apply to the **deductible**. *Doesn't apply if policy covers 2+ people.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$2,700** *Individual / **$5,400** Family Non-Network: **$6,000** *Individual / **$12,000** Family *Doesn't apply if policy covers 2+ people.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premium**, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain Pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see myuhc.com or call **1-866-633-2446**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-ins after ded.	50% co-ins after ded.	Virtual visits (Telehealth) – 20% co-ins after deductible per visit by a designated virtual network provider. No virtual coverage out-of-network.
	Specialist visit	20% co-ins after ded.	50% co-ins after ded.	None
	Other practitioner office visit	20% co-ins after ded.	50% co-ins after ded.	Cost share applies to manipulative (chiropractic) services only and is limited to 20 visits per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Preventive care / screening / immunization	No Charge	Not Covered*	Includes preventive health services specified in the health care reform law. *Certain services are covered when using a non-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network for sleep studies or benefit reduces to 50% of eligible expenses.
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay after ded. Mail-Order: $25 copay after ded.	Retail: $10 copay after ded.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: $35 copay after ded. Mail-Order: $87.50 copay after ded.	Retail: $35 copay after ded.	drugs may have a pre-authorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug costs are subject to the annual deductible.
	Tier 3 – Your Highest-Cost Option	Retail: $60 copay after ded. Mail Order: $150 copay after ded.	Retail: $60 copay after ded.	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	20% co-ins after ded.	50% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies
	Emergency medical transportation	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies
	Urgent care	20% co-ins after ded.	50% co-ins after ded.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician / surgeon fees	20% co-ins after ded.	50% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-ins after ded.	50% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Mental / Behavioral health inpatient services	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	20% co-ins after ded.	50% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Prenatal and postnatal care	No Charge	50% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	50% co-ins after ded.	Inpatient pre-authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	50% co-ins after ded.	Limited to 60 visits per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	20% co-ins after ded.	50% co-ins after ded.	Limits per calendar year: physical, speech, occupational – 20 visits; cardiac – 36 visits; pulmonary – 20 visits. Pre-authorization required for physical, occupational and speech non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Habilitative services	20% co-ins after ded.	50% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Skilled nursing care	20% co-ins after ded.	50% co-ins after ded.	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	20% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network for DME over $1,000 or no coverage. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	20% co-ins after ded.	50% co-ins after ded.	Inpatient pre-authorization is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	20% co-ins after ded.	Not Covered	Limited to 1 exam every 24 months. No coverage non-network.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Hearing aids
- Routine eye care (Adult/Child)
- Spinal Manipulation

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or myuhc.com or Colorado Division of Insurance at 1-303-894-7490 or dora.state.co.us/insurance.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,920
- **Patient pays** $2,620

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,400
Copays	$20
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$2,620**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,070
- **Patient pays** $2,330

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$900
Coinsurance	$90
Limits or exclusions	$40
Total	**$2,330**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

UnitedHealthcare®

Navigate Plan VX7 / 0BO

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** GIL

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-855-828-7715.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$500** Individual / **$1,500** Family Per calendar year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$3,000** Individual / **$6,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premium,** balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see myuhc.com or call **1-855-828-7715**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. An electronic referral is required to see a **Network Specialist**.	This plan will pay some or all of the costs to see a **specialist** but only if you have the plan's permission before you see the **specialist** for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-828-7715 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN. Virtual visits (Telehealth) – $10 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit	Not Covered	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$50 copay per visit	Not Covered	Not Covered	Cost share applies for only manipulative (chiropractic) services and is limited to 20 visits per calendar year.
	Preventive care / screening / immunization	No Charge	Not Covered	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins after ded.	20% co-ins after ded.	Not Covered	None
	Imaging (CT / PET scans, MRIs)	$150 copay per service	$150 copay per service	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at myuhc.com	Tier 1 – Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay	Retail: $15 copay Mail-Order: $37.50 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Your Midrange-Cost Option	Retail: $45 copay Mail-Order: $112.50 copay	Retail: $45 copay Mail-Order: $112.50 copay	Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: $60 copay Mail-Order: $150 copay	Retail: $60 copay Mail-Order: $150 copay	Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN. $75 outpatient surgery per occurrence deductible applies prior to the annual deductible.
	Physician / surgeon fees	20% co-ins after ded.	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN.
If you need immediate medical attention	Emergency room services	$300 copay per visit	$300 copay per visit	$300 copay per visit	None
	Emergency medical transportation	20% co-ins after ded.	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies.
	Urgent care	$75 copay per visit	$75 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded.	Not Covered	Not Covered	$150 inpatient stay per occurrence deductible applies prior to the annual deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician / surgeon fees	20% co-ins after ded.	Not Covered	Not Covered	Primary care provider (PCP) must be assigned. No referral required for OB/GYN.
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$50 copay per visit	$50 copay per visit	Not Covered	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. See your policy or plan document for additional information about EAP benefits.
	Mental / Behavioral health inpatient services	20% co-ins after ded.	20% co-ins after ded.	Not Covered	See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	$50 copay per visit	$50 copay per visit	Not Covered	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	20% co-ins after ded.	20% co-ins after ded.	Not Covered	See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	Not Covered	Not Covered	$150 inpatient stay per occurrence deductible applies prior to the annual deductible.
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	20% co-ins after ded.	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$25 copay per outpatient visit	$25 copay per outpatient visit	Not Covered	Limits per calendar year: physical, speech, occupational – 20 visits; cardiac – 36 visits; pulmonary – 20 visits.
	Habilitative services	$25 copay per outpatient visit	$25 copay per outpatient visit	Not Covered	Limits are combined with Rehabilitation Services limits listed above.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% co-ins after ded.	20% co-ins after ded.	Not Covered	Limited to 60 days per calendar year. (combined with inpatient rehabilitation).
	Durable medical equipment	20% co-ins after ded.	20% co-ins after ded.	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	20% co-ins after ded.	20% co-ins after ded.	Not Covered	None
If your child needs dental or eye care	Eye exam	$25 copay per outpatient visit	$25 copay per outpatient visit	Not Covered	Limited to 1 exam every 24 months.
	Glasses	Not Covered	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Hearing aids
- Routine eye care (Adult/Child)
- Spinal Manipulation

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or www.myuhc.com or Colorado Division of Insurance at 1-303-894-7490 or http://www.dora.state.co.us/insurance/.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-828-7715.

Chinese (中文): **如果需要中文的帮助**, 请拨打这个号码1-855-828-7715.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-828-7715.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-828-7715.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan{pays}** $5,420
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$20
Coinsurance	$1,100
Limits or exclusions	$200
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,520
- **Patient pays** $1,940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$1,600
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,940**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-855-828-7715 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

UnitedHealthcare®

Benefit Summary

Colorado - Choice Plus
HSA - Plan AGGW Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the Choice Plus Plan with an HSA?

Get network freedom and an HSA.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network. You can save money when you use the health savings account (HSA) and the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplushsa** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-insurance (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
20%	$1,350	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible - Combined Medical and Pharmacy		
What is a deductible?		
The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.		
> No one in the family is eligible for benefits until the family coverage deductible is met.		
Medical Deductible - Single Coverage	$1,350 per year	$3,000 per year
Medical Deductible - Family Coverage	$2,700 per year	$6,000 per year
Out-of-Pocket Limit - Combined Medical and Pharmacy		
What is an out-of-pocket limit?		
The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
> If more than one person in a family is covered under the Policy, the single coverage out-of-pocket limit does not apply.		
Out-of-Pocket Limit - Single Coverage	$2,700 per year	$6,000 per year
Out-of-Pocket Limit - Family Coverage	$5,400 per year	$12,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services - Emergency and Non-Emergency		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorders		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Cleft Lip and Cleft Palate Treatment		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (Cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees Limits are the same as those stated under the specific Benefit category in this Benefit Summary. Benefits are available when the Covered Health Services are provided by either Network or out-of-network providers, however the out-of-network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the out-of-network provider does not agree to accept the Network level of reimbursement.)	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Colorectal Cancer Screening		
	The amount you pay is based on where the covered health service is provided. The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles.	
Congenital Heart Disease (CHD) Surgeries		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met. Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hearing Aids for Adults		
Limited to $2,500 per year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Hearing Aids for Minor Children		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospitalization and General Anesthesia for Dental Procedures for Children		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required.
Lab, X-Ray and Diagnostics - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for sleep studies.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Services (Biologically and Non-Biologically Based Mental Illness)		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
Limited to $2,500 per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Testing and Treatment		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required for certain services.
Physician Fees for Surgical and Medical Services		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available except for Child Health Supervision Services and prostate cancer screening. A deductible will not apply for Child Health Supervision Services and prostate cancer screening.
Additional Preventive Care Services.	You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every 3 years.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met, except the co-insurance for prosthetic arms, legs, feet and hands is 20%. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Reconstructive Procedures		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 20 visits of pulmonary rehabilitation. 36 visits of cardiac rehabilitation. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of manipulative treatments.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)		
Limited to care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered up to 20 visits each for physical, occupational and speech therapy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Substance Use Disorder Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telemedicine		
	The amount you pay is based on where the covered health service is provided.	
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided.	Out-of-Network Benefits are not available.
Urgent Care Center Services		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	20% co-insurance, after the medical deductible has been met.	Out-of-Network Benefits are not available.
Vision Examination		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 24 months.	20% co-insurance, after the medical deductible has been met.	Out-of-Network Benefits are not available.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders 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.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 7 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under Hospitalization and General Anesthesia for Dental Procedures for Children and Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 7 of the COC. 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 Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate; as decribed under Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 of the COC. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, 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 accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 7 of the COC. 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 7 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 7 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. 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. 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.

Services your plan does not cover (Exclusions)

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 7 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 7 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 7 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 7 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 7 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 7 of the COC.

Mental Health and Substance Use Disorders

Mental Health and Substance Use Disorder Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, Mental Health and Substance Use Disorder 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. Outside of an initial assessment, treatments for the primary diagnoses of intellectual disabilities, learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, personality disorders (with the exception of dialectical behavior therapy for Borderline Personality Disorders) and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Outside of an initial assessment, all unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 7 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 8 of the COC.

Services your plan does not cover (Exclusions)

Neurobiological Disorders – Autism Spectrum Disorder

Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder for an Enrolled Dependent 19 years of age or older. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 7 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 8 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided as described under Preventive Care Services in Section 7 of the COC); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 15 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 7 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Services your plan does not cover (Exclusions)

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except: as decribed under Rehabilitation Services - Outpatient Therapy in Section 7 of the COC; or as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder; therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or as described under Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. 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 7 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting. This exclusion does not apply when the Covered Person is the surrogate for which Benefits are available as described under Pregnancy - Maternity Services in Section 7 of the COC. Donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Services your plan does not cover (Exclusions)

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 7 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 7 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. 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 7 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. This exclusion does not apply to hearing aids for minor children as described under Hearing Aids for Minor Children in Section 7 of the COC.

Services your plan does not cover (Exclusions)

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 7 of the COC and Schedule of Benefits; and not otherwise excluded in Section 8 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption (This exclusion does not apply to treatment for Injuries resulting from a Covered Peron's casual or nonprofessional participating in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding); related to judicial or administrative proceedings or orders except for Medically Necessary Mental Health Services regardless of whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system that we determine meet the definition of a Covered Health Service and for which Benefits are otherwise covered under the Policy as described under Mental Health Services in Section 7 of the COC; Medically Necessary Substance Use Disorder Services regardless of whether the treatment voluntary or court-ordered as a result of contact with the criminal justice or legal system, that we determine meet the definition of a Covered Health Service and for which Benefits are otherwise covered under the Policy as described under Substance Use Disorder Services in Section 7 of the COC; 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 7 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy, except as described under Examination of Covered Persons in Section 11 of the COC. Foreign language and sign language services. 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 we 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. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of pain is possible, or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area. Consultation provided by a provider by telephone or facsimile.

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UnitedHealthcare®

Benefit Summary

Colorado - Navigate
Navigate - Plan VX7 Modified

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the UnitedHealthcare Navigate® Plan?

Get a plan with a Primary Care Provider (PCP) to help coordinate your care.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time.

> **Select your personal PCP from the plan network.** Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.

> **You need to get online referrals from your PCP to see a network specialist.**

> **There's no coverage if you go out of network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.

> **Preventive care is covered 100% in our network.**

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/navigate** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$25	$500	20%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Deductible

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

> This benefit plan includes a per occurrence deductible that applies to certain common medical events. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual	$500 per year
Medical Deductible - Family	$1,500 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$3,000 per year
Out-of-Pocket Limit - Family	$6,000 per year

Your Costs

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits
Ambulance Services - Emergency and Non-Emergency	
	20% co-insurance, after the medical deductible has been met.
Autism Spectrum Disorders	
	The amount you pay is based on where the covered health service is provided.
Cleft Lip and Cleft Palate Treatment	
	The amount you pay is based on where the covered health service is provided.
Clinical Trials	
	The amount you pay is based on where the covered health service is provided.
Colorectal Cancer Screening	
	The amount you pay is based on where the covered health service is provided. The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles.
Congenital Heart Disease (CHD) Surgeries	
	20% co-insurance after you pay the $150 per occurrence deductible per Inpatient Stay and the medical deductible has been met (with a referral from your Primary Physician).
Dental Services - Accident Only	
	20% co-insurance, after the medical deductible has been met.
Diabetes Services	
Diabetes Self Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.
Diabetes Self Management Items:	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Durable Medical Equipment	
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	20% co-insurance, after the medical deductible has been met.
Emergency Health Services - Outpatient	
	$300 co-pay per visit. A deductible does not apply.
Hearing Aids for Adults	
Limited to $2,500 every year and a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	20% co-insurance, after the medical deductible has been met.
Hearing Aids for Minor Children	
	20% co-insurance, after the medical deductible has been met.
Home Health Care	
Limited to 60 visits per year.	20% co-insurance, after the medical deductible has been met.
Hospice Care	
	20% co-insurance, after the medical deductible has been met.
Hospital - Inpatient Stay	
	20% co-insurance after you pay the $150 per occurrence deductible per Inpatient Stay and the medical deductible has been met (with a referral from your Primary Physician).
Hospitalization and General Anesthesia for Dental Procedures for Children	
	The amount you pay is based on where the covered health service is provided.
Lab, X-Ray and Diagnostics - Outpatient	
	20% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	
	$150 co-pay per service. A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Mental Health Services (Biologically and Non-Biologically Based Mental Illness)	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	$50 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.
Neurobiological Disorders – Autism Spectrum Disorder Services	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	$50 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.
Ostomy Supplies	
Limited to $2,500 per year.	20% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Testing and Treatment	
	The amount you pay is based on where the covered health service is provided.
Physician Fees for Surgical and Medical Services	
	20% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 20% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Physician's Office Services - Sickness and Injury	
	$25 co-pay per visit for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. A deductible does not apply. $50 co-pay per visit (with a referral from your Primary Physician). A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health service is provided.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife (with a referral from your Primary Physician). A deductible does not apply.
Additional Preventive Care Services.	You pay nothing for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife (with a referral from your Primary Physician). A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.	
Prosthetic Devices	
Limited to a single purchase of each type of prosthetic device every 3 years.	20% co-insurance, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health service is provided.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment	
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 20 visits of pulmonary rehabilitation. 36 visits of cardiac rehabilitation. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of manipulative treatments.	$50 co-pay per visit for manipulative treatment (with a referral from your Primary Physician). A deductible does not apply. $25 co-pay per visit (for all other rehabilitation services). A deductible does not apply.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)	
Limited to care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered up to 20 visits each for physical, occupational and speech therapy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	$25 co-pay per visit. A deductible does not apply.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 20% co-insurance, after the medical deductible has been met (with a referral from your Primary Physician).
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	20% co-insurance, after the medical deductible has been met.
Substance Use Disorder Services	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	$50 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.
Surgery - Outpatient	
	20% co-insurance after you pay the $75 per occurrence deductible per date of service and the medical deductible has been met for services provided by your Primary Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 20% co-insurance after you pay the $75 per occurrence deductible per date of service and the medical deductible has been met (with a referral from your Primary Physician).
Telemedicine	
	The amount you pay is based on where the covered health service is provided.

Your Costs

Common Medical Event	Your cost if you use Network Benefits
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received at a designated facility.	The amount you pay is based on where the covered health service is provided.
Urgent Care Center Services	
	$75 co-pay per visit. A deductible does not apply.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.	
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$10 co-pay per visit. A deductible does not apply.
Vision Examination	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Limited to 1 exam every 24 months.	$25 co-pay per visit. A deductible does not apply.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders 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.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 7 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under Hospitalization and General Anesthesia for Dental Procedures for Children and Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in Section 7 of the COC. 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 Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate; as decribed under Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 of the COC. 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. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, 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 accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in Section 7 of the COC. 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 7 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 7 of the COC. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. 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. 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.

Services your plan does not cover (Exclusions)

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 7 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 7 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 7 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 7 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 7 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 7 of the COC.

Mental Health and Substance Use Disorders

Mental Health and Substance Use Disorder Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an initial assessment, Mental Health and Substance Use Disorder 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. Outside of an initial assessment, treatments for the primary diagnoses of intellectual disabilities, learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, personality disorders (with the exception of dialectical behavior therapy for Borderline Personality Disorders) and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Outside of an initial assessment, all unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 7 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 8 of the COC.

Services your plan does not cover (Exclusions)

Neurobiological Disorders – Autism Spectrum Disorder

Intellectual disability as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor disorders and communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder for an Enrolled Dependent 19 years of age or older. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 7 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 8 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided as described under Preventive Care Services in Section 7 of the COC); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 15 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 7 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Services your plan does not cover (Exclusions)

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except: as decribed under Rehabilitation Services - Outpatient Therapy in Section 7 of the COC; or as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder; therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or as described under Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. 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 7 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting. This exclusion does not apply when the Covered Person is the surrogate for which Benefits are available as described under Pregnancy - Maternity Services in Section 7 of the COC. Donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Services your plan does not cover (Exclusions)

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 7 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 7 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. 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 7 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. This exclusion does not apply to hearing aids for minor children as described under Hearing Aids for Minor Children in Section 7 of the COC.

Services your plan does not cover (Exclusions)

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 15 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 7 of the COC and Schedule of Benefits; and not otherwise excluded in Section 8 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption (This exclusion does not apply to treatment for Injuries resulting from a Covered Peron's casual or nonprofessional participating in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding); related to judicial or administrative proceedings or orders except for Medically Necessary Mental Health Services regardless of whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system that we determine meet the definition of a Covered Health Service and for which Benefits are otherwise covered under the Policy as described under Mental Health Services in Section 7 of the COC; Medically Necessary Substance Use Disorder Services regardless of whether the treatment voluntary or court-ordered as a result of contact with the criminal justice or legal system, that we determine meet the definition of a Covered Health Service and for which Benefits are otherwise covered under the Policy as described under Substance Use Disorder Services in Section 7 of the COC; 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 7 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy, except as described under Examination of Covered Persons in Section 11 of the COC. Foreign language and sign language services. 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 we 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. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of pain is possible, or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area. Consultation provided by a provider by telephone or facsimile.

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Colorado

10/35/60 Plan 2V

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Deductible - Network and Non-Network	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary

Out-of-Pocket Limit - Network	
Individual Out-of-Pocket Limit	See Medical Benefit Summary
Family Out-of-Pocket Limit	See Medical Benefit Summary

Out-of-Pocket Limit does not apply Non-Network.

Under this pharmacy coverage plan, a deductible and out-of-pocket maximum apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket maximum amounts.The deductible and the out-of-pocket maximum include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the co-payments listed below. If you reach the out-of-pocket maximum, you will not be required to pay a co-payment.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 2	**$35**	**$35**	**$87.50**
Tier 3	**$60**	**$60**	**$150**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

Other Important Information about your Outpatient Prescription Drug Benefits

If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drug Products require that you obtain prior authorization from us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

You may be required to fill an initial Prescription Drug Product order and obtain two refills through a retail pharmacy prior to using a mail order Network Pharmacy.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at myuhc.com or by calling Customer Care at the telephone number on your ID card.

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This does not include Prescription Drug Products that have been approved by the U.S. Food and Drug Administration (FDA) for use in the treatment of cancer but have not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services; and the treatment is for a Covered Health Service.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide through other arrangements, workers' compensation insurance for employees, owners, and/or partners.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Treatment for toenail Onychomycosis (toenail fungus).
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to prescribed over-the-counter FDA-approved contraceptives or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Service Task Force (USPSTF) when prescribed by a physician for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 7 of the COC.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymatic disorders as specified in Section 15 of the Pharmacy Rider.

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug

Navigate Colorado

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Maximum

Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	**$15**	**$37.50**
Tier 2	**$45**	**$112.50**
Tier 3	**$60**	**$150**

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drug Products require that you obtain prior authorization from us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

You may be required to fill an initial Prescription Drug Product order and obtain two refills through a retail pharmacy prior to using a mail order Network Pharmacy.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This does not include Prescription Drug Products that have been approved by the U.S. Food and Drug Administration (FDA) for use in the treatment of cancer but have not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services; and the treatment is for a Covered Health Service.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders as specified in Section 3 of the Pharmacy Rider.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

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UnitedHealthcare

Effective Date: 1/1/2017
Performance Standards and Credits
Effective for the period: January 01, 2017 through December 31, 2017

Category	Guarantee Description	Measurement Criteria	Credit Amount
Administrative Services			
Implementation	These guarantees apply only to the initial implementation.		
1. ID Cards.	99% mailed within 10 business days after final member eligibility is received, system loaded and passes a quality assurance check.	Date ID Cards are mailed.	**$15,000**
2. Electronic Claim Ready Date	Electronic Claim Ready by the effective date or within 18 business days after account structure is entered into the system, **final** member eligibility is received, and benefit plan design is finalized.	Date plan benefits and employee and dependent eligibility data is system loaded.	**$15,000**
3. Medical Eligibility Initial Implementation File	Load all medical eligibility to eligibility system within **2 business days** of receipt. This is applicable to ongoing files but does not apply to paper eligiblity (i.e. Spreadsheet Solutions/xTool). Also, all discrepancy reports need to be sent to client within 14 days of eligiblity being loaded.	Elapsed time from date file is received to the date upon which the electronic to the date upon which the electronic file is loaded into the eligibility system.	**$15,000**
Administrative Services			
Customer Phone Service			
1. Average Speed to Answer.	30 seconds or less Gradients are 32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds	Team level	 **$3,000** **$6,000** **$9,000** **$12,000** **$15,000**
2. Abandonment Rate.	2.00% Gradients are 2.01%-2.50% 2.51%-3.00% 3.01%-3.50% 3.51%-4.00% Greater than 4.00%	Team level	 **$3,000** **$6,000** **$9,000** **$12,000** **$15,000**
3. Call Quality Score	93.00% Gradients are 92.99%-91.00% 90.99%-89.00% 88.99%-87.00% 86.99%-85.00% Below 85.00%	Office level	 **$3,000** **$6,000** **$9,000** **$12,000** **$15,000**
Member Satisfaction			
1. Claimant & Key Customer Overall Satisfaction	80% satisfaction score based on % responding: Completely Satisfied, Very Satisfied and Somewhat Satisfied Products are PPO, POS, EPO, Managed Indemnity, HMO	Telephone Survey Based on UNET Service Center performance scores. Key Customer study may be conducted for an additional charge	**$7,500**
Overall UHC Satisfaction			
1. Employer health care decision makers	Based on the response to the question, "Overall, how satisfied are you with UnitedHealthcare?" If the response is a score of 5-10 on the 0-10 scale where 0 means very dissatisfied and 10 means very satisfied, the guarantee has been met.	Based on Employer health care decision makers' overall satisfaction with UnitedHealthcare.	**$7,500**
Total At Risk			**$105,000**

Medicare Supplemental plans are excluded from Performance Guarantees.

EXHIBIT B

Proof of Insurance

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/26/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH USA INC.
333 SOUTH 7TH STREET, SUITE 1400
MINNEAPOLIS, MN 55402-2427
Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307

401115--GAWX5-16-17

INSURED
UNITEDHEALTH GROUP
9900 BREN ROAD EAST
MINNETONKA, MN 55343

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Old Republic Insurance Company	24147
INSURER B :	XL Specialty Insurance Company	37885
INSURER C :	Travelers Property Casualty Company of America	25674
INSURER D :		
INSURER E :		
INSURER F :		

COVERAGES **CERTIFICATE NUMBER:** CHI-006039106-14 **REVISION NUMBER:** 13

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			MWZY307227	05/01/2016	05/01/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 2,500 $ 1,000,000 $ 3,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			MWTB307230	05/01/2016	05/01/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 2,000,000 $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			US00075258LI16A	05/01/2016	05/01/2017	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
C C C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		HC2JUB472M475516 (AOS) HRJUB472M476716 (MA & WI) HWXJUB472M477916 (XWC OH)	05/01/2016 05/01/2016 05/01/2016	05/01/2017 05/01/2017 05/01/2017	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
THE GENERAL LIABILITY POLICY INCLUDES A BLANKET ADDITIONAL INSURED ENDORSEMENT FOR PERSONS OR ORGANIZATIONS WHERE THE NAMED INSURED IS OBLIGATED TO PROVIDE SUCH STATUS BY WRITTEN CONTRACT OR AGREEMENT, ONLY TO THE MINIMUM EXTENT REQUIRED AND SUBJECT TO POLICY TERMS AND CONDITIONS.

CERTIFICATE HOLDER
UNITEDHEALTH GROUP
9900 BREN ROAD EAST
MINNETONKA, MN 55343

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Manashi Mukherjee Manashi Mukherjee

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/26/2016

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PRODUCER
MARSH USA INC.
333 SOUTH 7TH STREET, SUITE 1400
MINNEAPOLIS, MN 55402-2427
Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307

401115--GAWX5-16-17

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Old Republic Insurance Company	24147
INSURER B : XL Speciality Insurance Company	37885
INSURER C : Travelers Property Casualty Company of America	25674
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
UNITEDHEALTH GROUP
9900 BREN ROAD EAST
MINNETONKA, MN 55343

COVERAGES **CERTIFICATE NUMBER:** CHI-006039106-14 **REVISION NUMBER:** 13

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			MWZY307227	05/01/2016	05/01/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 2,500 $ 1,000,000 $ 3,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			MWTB307230	05/01/2016	05/01/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 2,000,000 $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			US00075258LI16A	05/01/2016	05/01/2017	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
C C C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		HC2JUB472M475516 (AOS) HRJUB472M476716 (MA & WI) HWXJUB472M477916 (XWC OH)	05/01/2016 05/01/2016 05/01/2016	05/01/2017 05/01/2017 05/01/2017	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
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CERTIFICATE HOLDER
UNITEDHEALTH GROUP
9900 BREN ROAD EAST
MINNETONKA, MN 55343

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Manashi Mukherjee Manashi Mukherjee

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/26/2016

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PRODUCER
Marsh USA Inc.
333 South 7th Street, Suite 1400
Minneapolis, MN 55402-2400
Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307

401115--Cyber-16-18

INSURED
UNITEDHEALTH GROUP
9900 BREN ROAD EAST
MINNETONKA, MN 55343

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Old Republic Insurance Company	24147
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** CHI-006351891-07 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	CYBER LIABILITY			MWZZ307229	05/01/2016	05/01/2018	EACH CLAIM	$10,000,000
							AGGREGATE	$10,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
EVIDENCE OF INSURANCE

CERTIFICATE HOLDER

UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008-W345
MINNETONKA, MN 55343

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/26/2016

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PRODUCER
Marsh USA Inc.
333 South 7th Street, Suite 1400
Minneapolis, MN 55402-2400
Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307

401115-OLD-PL5M-16-18

INSURED
UNITEDHEALTH GROUP
9900 BREN ROAD EAST
MINNETONKA, MN 55343

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Old Republic Insurance Company	24147
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** CHI-005923701-14 **REVISION NUMBER:** 12

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N / A (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Managed Care			MWZZ307228	05/01/2016	05/01/2018	Each Claim	$5,000,000
	Professional Liability/E&O			RETRO DATE: 1/1/77			Annual Aggregate	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008-W345
MINNETONKA, MN 55343

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/28/2016

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PRODUCER
MARSH USA INC.
99 HIGH STREET
BOSTON, MA 02110
Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307

401115-CORP-CRIME-16-17

INSURED
UNITEDHEALTH GROUP INCORPORATED
ATTN. RISK MANAGEMENT
9900 BREN ROAD EAST
MINNETONKA, MN 55343

CONTACT NAME:
PHONE (A/C, No, Ext): | **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Great American Insurance Co.	16691
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** CHI-006387410-01 **REVISION NUMBER:** 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

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	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	CRIME			SAA 425-98-68-01-00	05/01/2016	05/01/2017	LIMIT PER OCCURRENCE	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

UNITEDHEALTH GROUP
9900 BREN ROAD EAST MN008-W345
MINNETONKA, MN 55343

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

EXHIBIT C

Denver Logo Guidelines

DENVER

THE MILE HIGH CITY

CITY AND COUNTY OF DENVER LOGO GUIDELINES

These guidelines demonstrate how to correctly use the City and County of Denver logo.

UPDATED 2016



CONTENTS

TYPES OF LOGO FILES

EPS
Vector-based image that will not lose quality if scaled larger than the provided size. Available in four color process, spot color and black and white. Primarily used for professional printing.

JPEG
Both high and low-resolution pixel-based images that will lose quality if scaled larger than the provided size. Available in RGB format and black and white. Primarily used for in-house printing and for viewing on screen. This is also the preferred format for programs that are not design-based, such as Microsoft Word, Microsoft Excel, and Microsoft PowerPoint.

TYPES OF LOGO COLORS

Spot Color
Spot color printing uses pre-mixed ink colors determined by the Pantone Matching System (PMS). They accurately represent color chips provided to the print and design industry.

4 Color Process
Process printing uses four inks (cyan, magenta, yellow and black — also referred to as CMYK) printed together to create a wide spectrum of colors.

RGB Format
Colors are used in RGB (red, green and blue) format when they appear on computer or television screens.

Hex Numbers
Hexadecimal numbers or “hex” numbers are a base-16 numbering system used to define colors on web pages. A hex number is written from 0-9 and then A-F.

For copies of the logo in any format or questions about which file type you need, please contact the Denver Marketing Office at DenverMarketingOffice@DenverGov.org or 720-913-1633.



WHO CAN USE THE CITY AND COUNTY OF DENVER LOGO

DENVER
THE MILE HIGH CITY

DENVER
THE MILE HIGH CITY

The Denver D logo is available for use by city employees of the City and County of Denver for city department/agency purposes. The Denver logo may not be distributed to external entities (with the exception of the partnering agencies described below) without a licensing agreement.

The Denver D logo may be distributed to entities with which the City and County of Denver has executed a contract that includes, at a minimum, the following terms and conditions: required usage guidelines to include duration of use; purpose of use; and the corresponding collateral in which the Denver D logo will be placed. Licensing agreements may be obtained through the Denver Marketing Office and are subject to Executive Order No. 8.

For an outside entity to be considered for a licensing agreement authorizing them to use the Denver D logo, the city must be playing an active role in event or partnership or have a paid, documented sponsorship agreement. When the city does enter into a relationship as a sponsor, the sponsorship package must include phrasing that defines the acknowledgement of city support through the use of its logo to be eligible. For a copy of the city's sponsorship agreement please contact the Denver Marketing Office.

The city does not provide use of the logo for events or initiatives for which the city has supplied grant-funded support unless the event or initiative has a corresponding documented sponsorship component or agreement. If the city has provided a grant to an outside entity, that entity may recognize city support through written or spoken word unless the grant or contract providing grant funds provides otherwise.

The City and County of Denver does grant permission to use the Denver D logo to the city's exclusive partners, such as the VISIT DENVER, the Convention and Visitors Bureau and the Downtown Denver Partnership. All partnering agencies must follow the usage guidelines as described in the graphic standards. Distribution of the logo to outside entities by partnering agencies is unacceptable.



PRIMARY AND SECONDARY LOGOS

The City and County of Denver logo consists of three main elements: The primary D icon, the DENVER logotype and tagline.

Each of these elements has been custom-created and should never be recreated or re-typeset. To maintain consistency and create a strong visual identity, the Denver logo should only be used from existing digital files.

Please DO NOT use the Denver D icon without the DENVER logotype and tagline unless expressly permitted by this guide or the Denver Marketing Office.

PRIMARY LOGO
The horizontal version of the Denver logo (D icon to the left of the logotype) is the preferred logo format.

The logo utilizes the typeface Avenir Black for both DENVER and the tagline.

The distance to the right of the D icon and to left of the type should remain consistent. This distance is determined by the distance between the bottom of the tagline to the bottom of the DENVER logotype, represented by the letter X. The distance from the right edge of the D icon to the left edge of the logotype should be equal to X. The block of text in its entirety is centered vertically with the D icon.

SECONDARY LOGO
When the horizontal version of the Denver logo will not work with your space or design requirements, the secondary, stacked logo version can be used. Again, the distance between the bottom of the D icon and top of the DENVER logotype should be equal to X. The block of text in its entirety is centered horizontally with the D icon.



CLEAR ZONE, MINIMUM SIZES & TYPEFACES

CLEAR ZONE

The Denver logo should always have an area of open space or “clear zone” around it. No other graphic elements should fall within this area around the logo.

Where “X” is equal to the distance between the bottom of the tagline to the bottom of the DENVER logotype, leave at least X amount of clearance on all sides of the logo.

7/8"

5/8"

MINIMUM SIZES

The Denver logo should always be used at an appropriate size to make sure it is legible.

When the primary signature is used, it should be no smaller than 7/8” wide at the widest point. The secondary signature should be used no smaller than 5/8” at its widest point.

ITC Franklin Gothic Demi
ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890@#$%^&*!?/:;.”{}[]()

ITC Franklin Gothic Book
ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890@#$%^&*!?/:;.”{}[]()

TYPEFACES

The primary typeface used to accompany the Denver logo is ITC Franklin Gothic.

There are two typefaces in this family that are commonly used for Denver branded materials: Franklin Gothic Demi and Franklin Gothic Book.

Standard fonts such as Arial are permitted within documents created in programs where custom fonts are not available.



LOGO COLORS

The Denver logo color palette is comprised of five colors that represent this vibrant city.

Spot-color printing is the preferred option and should be used whenever possible. However, four-color process printing may be used when spot-color printing is not available or cost effective. When the logo is used on the on screen, the RGB format should be used and hex values should be used for the web. The Denver logo spot colors and their corresponding four-color process, RGB and hex formulas are listed below.

The color samples in this guide are just a visual representation of the colors and should not be used as an accurate color match. Actual Pantone chips should be used to match colors when printing.

	SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
BRICK RED	PMS 1805	C 0 M 91 Y 100 K 23	R 160 G 0 B 34	#C4161C
SKY BLUE	PMS 2925	C 85 M 24 Y 0 K 0	R 0 G 150 B 214	#0096D6
SUNSHINE GOLD	PMS 130	C 0 M 30 Y 100 K 0	R 253 G 185 B 19	#FDB913
MOUNTAIN PURPLE	PMS 268	C 82 M 100 Y 0 K 12	R 64 G 15 B 96	#491D74
80% BLACK	PANTONE PROCESS 80% BLACK PMS 425	C 0 M 0 Y 0 K 80	R 88 G 89 B 91	#58595B

Note: Palette colors pertain to both coated and uncoated stocks



REVERSE & ONE-COLOR USAGE

DENVER
THE MILE HIGH CITY

DENVER
THE MILE HIGH CITY
15%

DENVER
THE MILE HIGH CITY
50%

DENVER
THE MILE HIGH CITY
70%

FULL-COLOR REVERSE USAGE
A reverse version of the Denver logo has been developed for use when the logo appears on black or other dark colors. The D is not actually reversed, but uses a white border to separate it from the background. The logotype and tagline are white instead of black to increase legibility.

Use the regular signature on backgrounds with a color that has a tonal equivalency of 15% or less black and the reverse signature on backgrounds with a color that has a tonal equivalency of more than 15% black.

DENVER
THE MILE HIGH CITY

ONE-COLOR USAGE
An alternate version of the Denver logo has been developed to be used when only one color is available.

One-color logos should only be used as an alternative to the preferred full-color version. It should not be used in four-color process printing or in RGB formats, where you can use a full-color version instead.

DENVER
THE MILE HIGH CITY

ONE-COLOR REVERSE USAGE
When only one color is available and the logo appears on black or another dark color, a one-color reverse usage should be used. In this version, the primary D icon is used with a white border with the colored elements reversed to the background color.



INCORRECT USAGE

DO NOT reposition the elements of the logo.

DO NOT use the one-color reversed logo where the primary icon appears in solid white (see page 5 for the correct usage).

DO NOT change the colors of the logo.

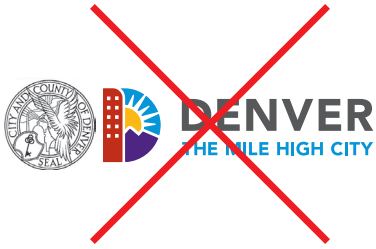
DO NOT distort or stretch the logo. Make sure it is always scaled proportionally.

DO NOT use the primary D icon as a decorative capital letter.

DO NOT place the logo on a background without sufficient contrast (see reverse applications on page 5).

DO NOT place the logo on a photographic background without sufficient contrast (see reverse applications on page 5).

DO NOT use the logo without all of the necessary elements.



DO NOT use the logo or primary icon in a way that violates the minimum clear space, especially in a co-branding situation.

DO NOT use the D icon locked up with any other typeface.



THE CITY FLAG AND THE CITY SEAL

THE CITY FLAG

The city flag graphic is not to be used as a replacement for the Denver D logo. The city flag image is to be associated only with an actual flag representing the City and County of Denver. All materials currently showcasing the city flag as a graphic image need to be phased out and replaced with the D logo (e.g., employee badges, city vehicles, brochures, etc.).

The city flag image is protected by common law rights.

THE CITY SEAL

The city seal is to be reserved for official city documents. Official documents include, but are not limited to, mayoral proclamations, legal documents and death certificates.

To the extent reasonable, city agencies and departments must transition to the updated business systems package for regular city business. The business system package includes letterhead, envelopes, and business cards which are available on the brand center. As appropriate, all marketing, informational and informal material – including websites, uniforms, brochures and other collateral material – should include the Denver D logo and exclude the city seal.

If you have any questions regarding logo usage policies please contact the Denver Marketing Office. If you have any questions regarding legal considerations around the use of the city seal, please contact the City Attorney's Office.



OFFICES WITHIN THE CITY

Offices within the city are able to use their own unique logo, as outlined below. It is also acceptable for the office to use the main City and County of Denver logo if they choose.

DEPARTMENTS AND AGENCIES

To maintain the integrity of the City and County of Denver logo when branding departments, offices and agencies within the city, the logo will still be comprised of three elements. The D icon and DENVER logotype will remain, but the name of the department will take the place of the tagline, THE MILE HIGH CITY. Please keep the DENVER logotype alignment the same as the main City and County of Denver logo.

When the name of the department is too long to fit onto one line, the text should flow to the second (or third, if applicable) line. The top of the department name will remain on the same level. Please try to split the name evenly onto two lines, and do not extend the name of the department further than approximately 50% beyond the length of DENVER. Please refer to **page 5** for reverse and one-color usage.

Please do not use the word “DENVER” in department name to avoid redundancy, and acronyms in the department name should be avoided whenever possible.

DIVISIONS WITHIN DEPARTMENTS AND AGENCIES

When branding programs that are contained within the city’s departments, offices and agencies, a new type configuration applies. The name of the program is set first in the position and ratio indicated below. The name of the parent department, office or agency moves to the second line, and always follows the word “Denver.”

If the name of the program is too long to fit onto one line, it should flow to the second line.

As with the primary Denver logo, the distance to the right of the D icon and to left of the type should remain consistent within program logos. Note that in these applications, all text elements move to align to the top of the D icon.

TAGLINES

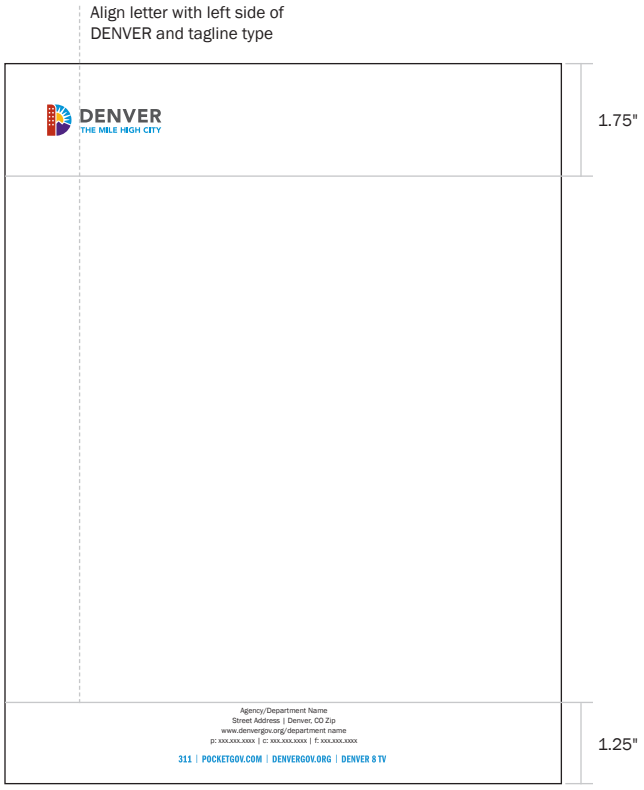
Please do not lock up taglines, mission statements, etc. to the logo when creating an office’s identity.

EXCEPTIONS

The three divisions of the Department of Safety and Denver International Airport are the only city offices that are permitted to continue using independent logos. The Denver D logo should still be co-branded with these agencies whenever appropriate.



LETTERSET



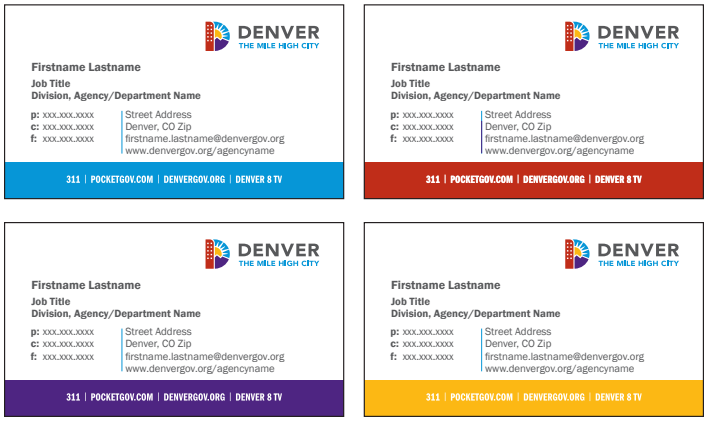
LETTERHEAD

This letterhead has also been set up as a Microsoft® Word template.

If the document is released from multiple divisions, please typeset only the primary department/agency contact information centered across the bottom to avoid confusion and maintain the specified layout.

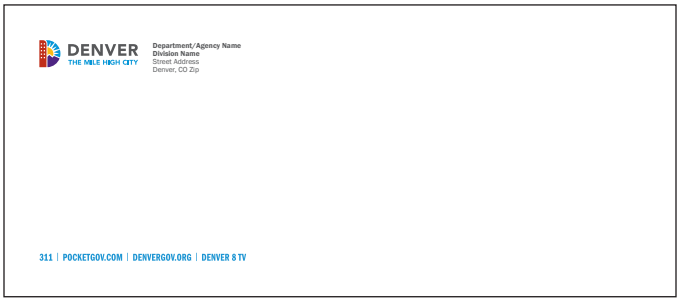
When typing a letter, align the left side of the text with the left side of the DENVER and tagline typography and begin typing 1.75" from the top of the page.

Leave a 1.25" margin at the bottom of the page to accommodate contact information.



BUSINESS CARDS

Visit the Brand Center at www.denvergov.org/brandcenter for electronic files and pre-printed shells. Do not attempt to recreate the business card artwork. Please do not add logos or other artwork to the back of the card.



#10 ENVELOPE

Visit the Brand Center at www.denvergov.org/brandcenter for electronic files and pre-printed shells. Do not attempt to recreate the envelope artwork.

For additional templates not provided within this document (i.e. pocket folders, press releases, presentations, etc.) please contact the Denver Marketing Office.



EMAIL SIGNATURES AND MOBILE GUIDELINES

DENVER
THE MILE HIGH CITY

First Name N. Lastname | Job Title
Division, Agency/Department | City and County of Denver
p: (xxx) xxx-xxxx | name.name@xxxxxxxxxxdenvergov.org

CONNECT WITH US | 311 | pocketgov.com | denvergov.org | Denver 8 TV | Facebook

EMAIL SIGNATURES

Email signatures should feature the horizontal version of the City and County of Denver logo below the email sender's information. Directly below this, the signature should additionally contain the city's four connection touch-points as illustrated in the example image on the right. This text graphic represents the four most common ways in which residents connect with the city for services, schedules, and information.

Please use a text-only version of the signature when responding to email changes so as not to unnecessarily increase the message file size. Agency or department specific logos, per page 8, are permitted in email signatures. However, it is the sole responsibility of the communications director in each department to create and distribute these templates in order to ensure that the graphic standards are maintained.

Personal quotes, background colors and patterns, etc., should not be used in the email signature. However, department mission statements are acceptable when necessary. It is also permissible to add certain standardized language, such as legal disclosure policies or requests to minimize paper usage.

Please note that Arial is used in place of Franklin Gothic in this application because it is a web-safe font.

Please refer to the Denver Brand Center to properly set up your email signature.



APP ICONS

Departments, agencies, divisions and programs within the City and County of Denver may have the opportunity to create mobile apps. When doing so, any primary, secondary or accent color can be utilized.

Glyph icons are used for mobile application toolbars, splash screens, navigation, and menus. Mobile application glyph icons must be designed as monochromatic symbols with an emphasis on minimalism and simplicity. Mobile app icons must provide easy recognition in formats as small as 32 x 32 pixels and must adhere to all size standards provided by the specific mobile application framework (iOS, Android, Windows Phone, etc.). They should be developed in vector format to be scalable up or down, depending on the required specifications.

The app icon should feature a simple, representative image reversed out on a city color. The icon should feature a solid color border and an embossed effect to give it dimension. Examples are at left; please note that customized icons should be approved by the Denver Marketing Office before they are used.



PROGRAM, VENUE AND EVENT LOGOS

DENVER
THE MILE HIGH CITY

Any office operating solely under the City and County of Denver, exclusively funded with taxpayer dollars and/or at the direction of the mayor should be using the Denver D as its primary logo. However, there are instances when a city program, venue or event may merit its own visual identity, such as in the case of a partnership with an external entity, when the initiative needs to be marketed broadly, or when legal or political considerations make the Denver D less preferred. In those scenarios, some basic quality assurances should be considered.

Please contact the Denver Marketing Office before a new logo is created.

Some guidelines to consider when designing a new program identity:

- **Logos & Symbols**
  Style matters. The symbol reflects Denver's energy, the amazing weather, outdoor lifestyle and economic vitality through the incorporation of the shining sun, blue skies, majestic mountains and downtown landscape. When creating a new program identity, try to be compatible with the design feel established by the Denver "D" icon.
- **Brand Recognition**
  It's important for our audiences to understand which programs are affiliated with the city. Please use the City and County of Denver logo and identity prominently on all materials. In applications where the Denver D cannot be featured prominently, such as on an independent website, please include prominent text explaining the affiliation with the city (e.g. "Red Rocks Amphitheater is a proud venue of the City and County of Denver.")
- **Co-Branding**
  Consider what other logos will appear with the new one and try to complement, instead of compete with them.
- **Color Palette**
  Always use colors from the approved palette. See page 12 for expanded colors.
- **Typefaces**
  When it comes to font personality, a little goes a long way. Try to stay within the Franklin Gothic font family when possible.
- **Simplification**
  Logos should rarely have more than a couple colors and distinct elements (mark, typeface, tagline).
- **Scalability**
  Logos should have the ability to be used in very large or very small formats, meaning that high resolution versions should be developed and too many elements should be avoided.
- **Section 508 Web Color Contrast**
  Web Content Accessibility Guidelines (WCAG 1.0) require that there be a sufficient level of tonal contrast between colors so that low-vision users can read content on colored backgrounds. Guidelines for ensuring color combinations include:
  - Select color combinations that can be differentiated by users with color deficiencies;
  - Use tools to see what color combinations will look like when in black and white as seen by color-deficient users;
  - Ensure that the lightness contrast between foreground and background colors is high;
  - Increase the lightness contrast between colors on either end of the spectrum (e.g., blues and reds); and
  - Avoid combining light colors from either end of the spectrum with dark colors from the middle of the spectrum.

Please contact the Denver Marketing Office with any questions regarding program identity best practices.



EXPANDED PALETTE

DENVER
THE MILE HIGH CITY

Although the main logo is comprised of five colors, city programs may use colors in the expanded palette for identity development and other graphic design. The expanded palette includes four secondary colors and four accent colors.

PRIMARY PALETTE

SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
PMS 1805 BRICK RED	C 18 M 0 Y 100 K 31	R 159 G 166 B 23	#9FA617
PMS 2925 SKY BLUE	C 100 M 58 Y 0 K 21	R 0 G 85 B 150	#005596
PMS 130 SUNSHINE GOLD	C 0 M 51 Y 100 K 1	R 243 G 144 B 29	#F3901D
PMS 268 MOUNTAIN PURPLE	C 0 M 79 Y 100 K 11	R 217 G 83 B 30	#D9531E
PANTONE PROCESS 80% BLACK 80% BLACK			

SECONDARY PALETTE

SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
PMS 384 YELLOW GREEN	C 18 M 0 Y 100 K 31	R 159 G 166 B 23	#9FA617
PMS 294 BRIGHT BLUE	C 100 M 58 Y 0 K 21	R 0 G 85 B 150	#005596
PMS 152 ORANGE	C 0 M 51 Y 100 K 1	R 243 G 144 B 29	#F3901D
PMS 180 RED ORANGE	C 0 M 79 Y 100 K 11	R 217 G 83 B 30	#D9531E

ACCENT COLORS

SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
PMS 296 NAVY	C 100 M 46 Y 0 K 70	R 0 G 45 B 86	#002D56
PMS 7496 BRIGHT GREEN	C 40 M 0 Y 100 K 38	R 109 G 141 B 36	#6D8D24
PMS 420 LIGHT GRAY	C 0 M 0 Y 0 K 15	R 220 G 221 B 222	#DCDDDE
PMS 7501 CREAM	C 0 M 4 Y 20 K 6	R 241 G 227 B 197	#F1E35C

Note: Palette colors pertain to both coated and uncoated stocks



EXPANDED PALETTE: SUGGESTED USAGE

DENVER
THE MILE HIGH CITY

When selecting colors for a new program identity, please choose from the primary and expanded palette.

While it is not required to use a primary palette color, it is recommended to maintain brand recognition throughout subbbrands.

Example Palette 1

Example Palette 2

Example Palette 3

You may use up to all four colors in the secondary palette, but please do not exceed five colors overall in identity development.

Example Palette 1

Example Palette 2

Example Palette 3

If you are using one or more accent color (up to three), please use at least one color from the primary or secondary palette.

Do not use a color from the accent palette as the dominant color in the application.



ALLIED ORGANIZATIONS AND CO-BRANDING

EXISTING ALLIED ORGANIZATIONS

It is recognized that there are several organizations that are closely aligned with the City and County of Denver, which each have their own brand personality. Examples of these organizations include the Denver Zoo, the Denver Botanic Gardens, Denver Water, and Denver Public Schools. These organizations are not required to rebrand to align with the new branding standards.

DENVER BOTANIC GARDENS

x

DENVER
THE MILE HIGH CITY

.75 X

ALLIED ORGANIZATION CO-BRANDING WITH THE CITY OF DENVER

Allied organizations with their own brand personality are not required to include the City and County of Denver logo on their collateral. However, if they decide to do so and have met the requirements outline on page 1, the City and County of Denver logo usage must comply with this guide and it must visually be at least 75% of the allied organization's logo. Additionally, please do not lockup the allied organization and City and County of Denver's logo, or use parts of the Denver logo within the allied organization's logo. Maintain clear space defined on **page 3**.

DENVER BOTANIC GARDENS

DENVER
THE MILE HIGH CITY

(Maintain clear area defined on p. 3)

CO-BRANDING PARTNERING AGENCIES AND SPONSORS

The City and County of Denver often partners with outside entities to promote a program or service. When partnering with outside organizations it is acceptable, if granted permission by both entities, to place their logos side by side with the Denver D.



GLOSSARY OF TERMS

Accent Color — A palette chosen to accent or support main colors utilized in identity development.

Clear Zone — Logo guidelines often specify a clear zone surrounding the logo. No other art or type should encroach on the clear zone.

Co-Branding — If two logos appear together to imply a cooperative effort, it is called co-branding. Logos used in co-branding should always respect the necessary clear space surrounding each logo.

Digital File — Digital files that are prepared by graphic designers to be printed or to be uploaded to web sites.

Foreground — The visual plane in an image closest to the viewer.

Four-Color Process — Process printing uses four inks (cyan, magenta, yellow and black — also referred to as CMYK) printed together to create a wide spectrum of colors.

Graphic Standards — An organization's requirements for reproducing its graphics and branding elements on all surfaces.

Glyph Icons — A graphic symbol that provides the appearance or form for a character. A glyph can be an alphabetic or numeric font or some other symbol that pictures an encoded character.

Hex Colors — Hexadecimal numbers or "hex" numbers are a base-16 numbering system used to define colors on web pages. A hex number is written from 0-9 and then A-F.

Lockup — The final form of a logo and a icon with all of the elements locked in their relative positions. For the sake of maintaining consistency in all mediums and to create a sense of cohesion between the elements, the lockup should not be taken apart or altered in any way.

Logotype — Logotype refers specifically to a word integrated into the logo.

Mobile Application — Also known as an app, a mobile application is a term used to describe software that runs on smart phones and mobile phones.

Monochromatic — Containing or using only one color.

Navigation — A user interface element within a webpage that contains links to other sections of the website.

Pixels — A physical point in a raster image, or the smallest addressable element in a display device; so it is the smallest controllable element of a picture represented on the screen.

Primary Icon — An organization's predominant mark; the preferred logo to be used on collateral.

Primary Palette — The main colors that comprise an organization's identity.

Raster Image —In computer graphics, a raster image, or bitmap, is a dot matrix data structure representing a generally rectangular grid of pixels, or points of color, viewable via a monitor, paper, or other display medium. Raster images are stored in image files with varying formats.

Re-Typeset — To re-typeset essentially means to re-type. It is never acceptable to re-type the words in a logo or tag line; instead always use the artwork provided.

Reverse Logo — A reverse logo is used when a logo appears on a dark background color that doesn't provide enough contrast. In order to make the logo more legible, the logo colors are changed to white.

RGB Format — Colors are used in RGB (red, green and blue) format when they appear on computer or television screens.

Scalable — An icon or logo's ability to be reduced or blown up in size.

Secondary Palette — Colors chosen to support the primary palette in an organization's identity.



GLOSSARY OF TERMS CONTINUED

Splash Screen — An image that appears while a computer program is loading. It may also be used to describe an introduction page on a website.

Spot Color — Spot color printing uses pre-mixed ink colors determined by the Pantone Matching System (PMS). They accurately represent color chips provided to the print and design industry.

Tagline — Tagline refers to a few word description that often accompanies a logo to make it more descriptive.

Tonal Contrast — The difference between the light and dark areas in a composition.

Typeface — Typeface is the same as “font.” A font or typeface is a professionally designed alphabet. Most logo guidelines specify the typeface to use with the logo.

Typesetting — Before computers became a part of design and printing, words were prepared for print by manually setting individual letters in the right sequence: “typesetting.” The term is still used to describe preparation of letters and words for print. If you choose a font and letter size for placement in a document, you are “typesetting.”

Vector — An image made up of solids, lines and curves that can be scaled or edited without affecting image resolution.

Web-Safe Font — A set of fonts that appear on a large percentage of computers. Common Web-safe fonts include: Arial, Courier New, Times New Roman, Georgia, Trebuchet, and Verdana.