REVIVAL AND THIRD AMENDMENT TO AGREEMENT BETWEEN THE CITY AND COUNTY OF DENVER AND UNITED HEALTHCARE SERVICES, INC.

THIS REVIVAL AND THIRD AMENDMENT ("**Third Amendment**") is entered into by and between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado ("City"), and **United HealthCare Services, Inc.,** 185 Asylum Street, Hartford, CT 06103-0450 ("**Insurance Company**"), jointly ("the Parties").

RECITALS

WHEREAS, the Parties previously entered into an agreement dated February 2, 2023 (contract number CSAHR 202265732-00) and amended that agreement twice through written agreements identified as: CSAHR-202265732-01 on February 29, 2024 and CSAHR-202265732-02 on January 13, 2025, (collectively referred to as the "**Agreement**"), for the Insurance Company to provide services described therein.

WHEREAS, Paragraph 4 of the Agreement (entitled "**Term**"), provided for a contract end date of December 31, 2025.

WHEREAS, the Parties experienced unforeseen delays with the 2026 renewal, though the Insurance Company has continued to provide uninterrupted service to the City.

WHEREAS, the Parties wish to revive the agreement and amend it to update for 2026 coverage terms, to modify and extend the term, to increase the maximum contract amount for the 2026 coverage year and to update Article 32 paragraph a. regarding confidential information as set forth in detail, below.

NOW, THEREFORE, in consideration of the premises and the mutual covenants and agreements contained in the Agreement and hereinafter set forth, the Parties agree as follows:

1. The Agreement is hereby revived.

2. **Updated Exhibit A-1.1**. That effective January 1, 2026, the attached Exhibit A-1.1, (2026 updates to Administrative Services Agreement) attached hereto, shall be attached to and incorporated into the Original Agreement as the new Exhibit A-1.1,

modifying existing Exhibit A-1;

3. **Updated Exhibit A-3.1**. That effective January 1, 2026, the attached Exhibit A-3.1 (2026 updates to Stop Loss Policy) attached hereto, shall be attached to and incorporated into the Original Agreement as the new Exhibit A-3.1, modifying the existing Exhibit A-3;

4. **Updated Exhibit A-4.1.** That effective January 1, 2026, the attached Exhibit A-4.1 (2026 updates to EAP Administrative Services Agreement) attached hereto, shall be attached to and incorporated into the Original Agreement as the new Exhibit A-4.1, modifying the existing Exhibit A-4;

5. **New Exhibits A-5, A-6 and A-7**. Exhibit A-5 (Choice Doctor's Plan), Exhibit A-6 (HSA Choice Plus Plan), and Exhibit A-7 (2026 Choice Plan Denver Health PPO) are hereby added as the new Exhibits to the Agreement.

6. **Modification of Term**. The first sentence of Paragraph 4 of the Agreement (entitled "**Term**") is hereby amended to read as follows:

> "4**.** **TERM:** This Agreement is effective beginning on **January 1, 2023**, and shall expire at 11:59 p.m. on **December 31, 2027** (the "**Term**")."

7. **Modification of Compensation and Payment**. Article 5, paragraph b. of the Original Agreement is hereby amended to read as follows:

> "5**.** **COMPENSATION AND PAYMENT:**
>
> **b.** **Maximum Contract Amount:** Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed **FOUR HUNDRED FIFTEEN MILLION DOLLARS AND NO CENTS ($415,000,000.00)** (the "Maximum Contract Amount"). The amount and frequency of billing and the detail required on each periodic bill shall be as agreed with the Executive Director. 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 the **Exhibits**. Any services performed beyond those in the **Exhibits** are performed at Insurance Company's risk and without authorization under the Agreement."

8. **CONFIDENTIAL INFORMATION**. Article 32 paragraph a. of the Original Agreement is hereby amended to read as follows:

> **City Information:** Each Party acknowledges and accepts that, in performance of all work under the terms of this Agreement, the other Party may have access to Proprietary Data or confidential information that may be owned or controlled by the other Party, and that the disclosure of such Proprietary Data or information may be damaging to the other Party or third parties. Each Party agrees that all Proprietary Data, confidential information or any other data or information provided or otherwise disclosed by the other Party shall be held in confidence and used only in the performance of its obligations under this Agreement, or as otherwise allowed under an Attachment to this Agreement. Each party shall exercise the same standard of care to protect such Proprietary Data and information as a reasonably prudent Party 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 one Party by the other Party. Such Proprietary Data may be in hardcopy, printed, digital or electronic format. Neither party may a) sell, license, or grant any other rights to the other Party's Confidential Information, (b) use the other Party's Confidential Information for the creation, operation or improvement of any product, service or database for external or commercial use, or c) use the other Party's Confidential Information to contract with or manage healthcare or pharmacy providers, coalitions or networks.

9. This Amendment may be executed in counterparts, each of which shall be deemed to be an original, and all of which, taken together, shall constitute one and the same instrument.

10. Except as herein amended, the Agreement is affirmed and ratified in each and every particular.

Contract Control Number: CSAHR-202265732-03
Contractor Name: UNITED HEALTHCARE SERVICES, INC.

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:

Attorney for the City and County of Denver

By: _____

REGISTERED AND COUNTERSIGNED:

By: _____

By: _____

Contract Control Number: CSAHR-202265732-03
Contractor Name: UNITED HEALTHCARE SERVICES, INC.

By: Signed by: Holly Durinick 83324C0E9DF042B...

Name: Holly Durinick
(please print)

Title: Regional Contract Manager
(please print)

EXHIBIT A-1.1

UPDATES TO SELF-FUNDED BENEFITS PLAN
2026 UPDATED ADMINISTRATIVE SERVICES AGREEMENT

UNITED HEALTHCARE SERVICES, INC.
FINANCIAL RENEWAL AND TERMS AMENDMENT

This Amendment ("Amendment") is made to the Master Purchase Agreement ("Agreement") by and between United HealthCare Services, Inc. ("United") and City and County of Denver ("Customer"), Contract No. 717340, and is effective on January 1, 2025 unless otherwise specified.

Any capitalized terms used in this Amendment have the meanings shown in the Agreement. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

The agreements that are being amended include any and all amendments, if any, that are effective prior to the effective date of this Amendment.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the agreements other than as stated herein.

The parties, by signing below, agree to amend the agreements as contained herein.

City and County of Denver

By _____

Authorized Signature

Print Name _____

Print Title _____

Date _____

United HealthCare Services, Inc.

By _____

Authorized Signature

Print Name _____

Print Title _____

Date _____

EXHIBIT B – FEES

These are the Fees Customer agrees to pay to United in exchange for the Services.

Medical Fees

The following financial terms are effective for the period January 1, 2026 through December 31, 2027, unless otherwise specified.

PEPM means Per Employee Per Month

Final Claims Fiduciary: United

Customer acknowledges that UHC Hub products and services are offered and provided by third party vendors that are not affiliated with United. UHC Hub vendors are subcontractors under the Agreement. Customer agrees that United is not responsible or liable in any way for performance guarantees or financial return guarantees made by those third party vendors. Certain UHC Hub products are subject to state sales Tax. United will invoice and Customer agrees to pay United for any required taxes. A third party vendor's participation in UHC Hub may terminate in the middle of the Initial Term or Renewal Term of this Agreement. In that instance, the product or service will no longer be provided from that vendor and no further Fees will be charged for that product or service. Fees for UHC Hub products and services will be paid through a withdrawal from the Bank Account.

ASO Fees (PEPM)	Current	Year 1	Year 2
Plan Year	01/01/2025 through 12/31/2025	1/1/2026 through 12/31/2026	1/1/2027 through 12/31/2027
POS	*$45.13*	$45.13	$46.03
EPO	*$45.13*	$45.13	$46.03
Credits			
Wellness Credit	$525,000	$525,000	$525,000

The following services may require an additional cost as noted below:

In total, Other Fees defined in this section are subject to the Maximum Contract Amounts recited in the Master Purchase Agreement between the parties.

Additional Disease Management, Specialty and Wellness Programs (Fees are on a PEPM basis unless specifically noted)	Current 1/1/2025 through 12/31/2025	Year 1 1/1/2026 through 12/31/2026	Year 2 1/1/2027 through 12/31/2027
Disease Management Programs:			
Congestive Heart Failure (VOM)	Included in Personal Health Support	Included in Personal Health Support	Included in Personal Health Support
Chronic Obstructive Pulmonary Disease (VOM)			
Coronary Artery Disease (VOM)			
Asthma Program (VOM)			
Diabetes Program - Comprehensive Engagement	Included	Included	Included
Clinical Specialty Network Programs:			
Bariatric Resource Services (BRS)	Included	Included	Included
Fertility Solutions	Included	Included	Included
Medical Management Programs			
Core Medical Necessity	Included	Included	Included
Physical Health Solutions:			
Chiropractic Network	Included	Included	Included
Physical Therapy/Occupational Therapy/Speech Therapy Network	Included	Included	Included

Complementary Alternative Medicine (CAM) Network Management	Included	Included	Included
Other Programs/Services:			
PHS 3.0 Tier 3	Included	Included	Included
Advocate4me Elite Alliance	Included	Included	Included
Behavioral Health Solutions	Included	N/A	N/A
Behavioral Health Solutions Pkg 1	N/A	Included	Included
Claim Fiduciary	Included	Included	Included
Onsite EAP	N/A	$452,532 annually	$463,845.36 annually
On Site Nurse Liason	N/A	Included	Included
SMS – MSK Only	Included	Included	Included
Other Programs/Services (Fees collected through Bank Account):			
Maven Maternity 12 Month Program	$925 Per Case	$925 Per Case	$925 Per Case
UHC Hub Vendors:			
Fees for the following will be collected through the Bank Account			
Hinge ACS Session 1	N/A	$250 Per Enrolled Participant	$250 Per Enrolled Participant
Hinge ACS Sessions 2+	N/A	$50 Per Enrolled Participant per Session	$50 Per Enrolled Participant per Session

The following are not included in the above ASO Fees:

Additional Services (Fees Collected through Bank Account unless otherwise noted)	Fee
Naviguard	25.00% of savings ***The fee per individual claim for Naviguard will not exceed $15,000.00 per claim.** ***Annual Naviguard fees not to exceed $15 pspm for 2026 and $16 pspm for 2027**
Transplant Resource Services Transplant Cost Negotiation Program	$8,333 per negotiation (charged in year end reconciliation)
Payment Integrity:	
Coordination of Benefits	30% of the gross recovery or prevented amount
Pre-Pay	30% of the gross recovery or prevented amount
Post-Pay	30% of the gross recovery amount
Subrogation Services	33.3% of the gross recovery amount

Service Description
Fees for the programs are listed above.
Coordination of Benefits: Prospective use of analytics, algorithms, and proprietary datasets to identify members that have other insurance as primary
Pre-Pay: Prospective services to help ensure accurate claim payment. • Detection and recovery of wasteful, abusive, and/or fraudulent claims. • Search claims for patterns which indicate possible waste or error by identifying specific claims for additional review or for an adjustment. • Evaluate claims to identify inappropriate levels of care, coding, and/or resource utilization. • Review of claims for inappropriate billing of services not documented in clinical notes by Board certified, same-specialty medical directors. • Prospective review of facility claims based on an itemized bill review. Analytics identify claims, record request sent to provider, claim is adjusted/denied based on review of those records • More expansive edits after the internal payment policy edits and are more expansive to identify claims that may need an adjustment.
Post-Pay: Retrospective services to help ensure accurate claim payment.

• Detection and recovery of wasteful, abusive, and/or fraudulent claims. • Search claims for patterns which indicate possible waste or error by identifying specific claims for additional review. • In-depth review of hospital medical records or other related documentation compared to claimed amounts to ensure billing accuracy. • Review, validate, and recover credit balances (dollars) on existing patient accounts through a combination of analysis and technology, on-site at hospitals and facilities. • Large-scale analytics to identify additional recovery opportunities; claims re-examined every month for up to 12 months.
Subrogation: Services to prevent the payment of Plan benefits, or recover Plan benefits, which should be paid by a third party. • Plan benefits, which should be paid by a third party. • Does not include benefits paid in connection with coordination of benefits, Medicare, or other Overpayments. • Customer will not engage any entity except United to provide such services without prior United approval.
Litigation and Arbitration Fees for Recoveries • Litigation or arbitration to recover any Overpayments and other Plan recovery opportunities. • Outside attorneys' fees and costs directly incurred with litigation or arbitration. • Pre-adjudicated claims or post-adjudication claims.
Payment Integrity Service Fees related to pre-adjudicated or prevented amount savings are calculated using logic that accounts for claim level detail and past claims payment experiences, and other relevant inputs including, but not limited to, historical amounts billed and allowed for similar providers, services, and specialties.

The following are included in the ASO Fees (applies to Active and Pre-65 Retiree population only):

- UnitedHealthcare Pharmacy. If the pharmacy is carved out to another vendor, the ASO fees and Credits are subject to change.
- eServices Reporting - (interactive fully Web-based reporting).
- Federal External Review Program (third level appeals) - our Medical ASO fee includes a maximum of 5 reviews. Reviews in excess of this limit will be charged at $500 per review.
- Advocate4Me Customer Service Model that provides participants with access to a one-stop advocacy resource for an unprecedented range of needs, including support and access to services across medical benefits, claims, pharmacy, clinical, incentives, and more.
- Customer Service, our quoted customer service model offers members a high-touch, personal guide who provides support in navigating benefits, understanding payment options, resolving claim issues and working through the health care system. In addition to acting as a one-stop shop where members can be directed to the most appropriate existing services, representatives can provide additional information relevant to personal needs and take ownership of inquires end-to-end. For those not resolved during the initial call, customer service representatives take ownership until resolution including call back to the member.
- Employer Internet Solution – www.employereservices.com.
- Our quote includes the management of over 100 disease states/conditions, as part of our Personal Health Support (PHS) program. We believe this approach will adequately address the clinical conditions present within the population - though we are open to discussing and proposing alternative programs, should clinical prevalence indicate an appropriate ROI.
- Consumer Activation, including basic navigation guide, health statements with individualized messaging, advanced concierge call services, and access to member portal with consumer activation messaging.
- UnitedHealthcare will duplicate requested plan of benefits in principle and in a manner compatible with our understanding of the basic plan designs.

Our quotation may be adjusted contingent upon review of all Medical plan design specifics. Our fees may be adjusted, or changes to the plans may be required to enable us to administer claim payments.

Pricing Assumptions:

- The Plan or its sponsor is responsible for state or federal surcharges, assessments, or similar taxes or fees imposed by governmental entities or agencies on the Plan, Plan Sponsor or us, including but not limited to those imposed pursuant to the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended from time to time. This includes responsibility for determining the amount due, funding, and remitting the PPACA Transitional Reinsurance fee and the PCORI fee which are remitted to the government (federal and/or state).
- The fees quoted do not include state or federal surcharges, assessments, or similar taxes/fees imposed by governmental entities or agencies on the Plan, Plan Sponsor or UnitedHealthcare. We reserve the right to adjust the rates (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in plan design or procedures required by the applicable regulatory authority or by the sponsor; and (iii) as otherwise permitted in the Administrative Services Agreement.
- The administrative fees set forth herein do not include fees related to the requirements set forth in the Consolidated Appropriations Act, 2021, including the No Surprises Act. Additional fees for these new regulatory requirements will be provided at a future date once regulatory guidance is received and final compliance requirements are determined.

- UnitedHealthcare reserves the right to revise this quotation under the following circumstances:
  - The total number of enrolled medical employees varies by more than 10 percent from the assumed medical enrollment of 5508.
  - The average contract size, defined as the total number of enrolled employees plus dependents divided by the total number of enrolled employees, varies by 10 percent or more from the assumed average contract size of 1.96.
  - The benefits or service requirements requested and/or quoted change prior to or after the effective date.
  - In the event of any changes in federal, state or other applicable legislation or regulation that require changes to this quotation.
  - In the event of any changes in plan design required by the applicable regulatory authority or by the Plan sponsor.
  - In the event that any taxes, surcharges, assessments, or similar charges are imposed by governmental entities or agencies on the Plan or UnitedHealthcare, in its role as administrator or insurer.

- As otherwise permitted in our Administrative Services Agreement
- Our quotation excludes the processing of runout claims upon the termination of our contract.
- If pharmacy benefits are carved out the ASO fees quoted above may be revised.
- Customer will only receive Rebates to the extent that Rebates are actually received by United. For example, if a government action or a major change in pharmaceutical industry practices eliminates or materially reduces manufacturer Rebate programs, Customer's payment amount may be reduced or eliminated. In such event, United shall promptly notify Customer and revise or eliminate such payment effective with the date of the reduction or elimination in Rebate payments. In addition, reduction or elimination of Rebates in this event shall constitute a change in the Agreement as described in the Fees Section such that United has the right to increase the fees for the Pharmacy Benefits Management services or increase the percentage of Rebate dollars retained by United.
- We reserve the right to adjust our rebate guarantee if changes made to our prescription drug list (PDL) for the purpose of achieving lower net drug cost for Customer and our other ASO customers result in significant reductions to the rebate level.
- Quoted fees include United retention of all medical benefit Rx rebates
- Commissions are excluded.
- This quotation assumes United will retain claim fiduciary responsibility
- United will provide a Wellness Credit to help Customer mitigate costs associated with additional wellness services from United These credits are available as follows:
  - The parties must have an executed Agreement.
  - The first month of service fees under the Agreement has been received by United.
  - Customer's enrollment with United must always exceed 4957 Employees.
  - Credits must be used between 01/01/2026 and 12/31/2026. Any Credits not used during this time period are forfeit.
  - Upon request from Customer, a credit will be issued in United's fee billing system.
  - Upon presentation of receipts for costs, a credit will be issued in United's fee billing system in the amount of the receipted expenses, total amount not to exceed the full credit.
  - If Customer terminates the Agreement prior to 12/31/2027, Customer will repay United a prorated portion of the credit paid in the year of termination based on the termination date. Credits in prior years are not subject to repayment. All unpaid credits are forfeit.
  - If enrollment with United falls below the enrollment threshold, Customer will repay United an amount proportional to the enrollment reduction based on the amount of the credit paid at the time enrollment falls below the threshold.
  - The amount of the credit not yet paid is reduced proportional to the enrollment reduction. If during the course of the first year unforeseen or additional expense items arise related to the Customer implementation, United reserves the right to use a portion of this credit to offset such expenses.

- Customer acknowledges that UHC Hub products and services are offered and provided by third-party vendors that are not affiliated with United. UHC Hub vendors are subcontractors under this Agreement. Customer agrees that United is not responsible or liable in any way for such performance guarantees or financial return guarantees made by those third party vendors. Certain UHC Hub products are subject to state sales Tax. United will invoice and Customer agrees to pay United for any required taxes.
- A third-party vendor's participation in UHC Hub may terminate in the middle of the Initial Term or Renewal Term of this Agreement. In that instance, the product or service will no longer be provided from that vendor and no further Fees will be charged for that product or service. Fees for UHC Hub products and services will be paid through a withdrawal from the Bank Account.

Other

A United affiliate provides payment services to the healthcare industry and offers medical providers with various payment methods and options, including electronic payments, virtual cards and checks. Some options are available to medical providers for a fee and may result in the receipt of transaction fees or other compensation (e.g., 1% to 3% of the total transaction amount) by a United affiliate.

EXHIBIT C – PERFORMANCE STANDARDS FOR HEALTH BENEFITS

The Fees at risk do not include Customer-elected optional and non-standard programs Fees, all credits, Payment Integrity Programs Fees, Out-of-Network Programs Fees, Commission Funds, Consultant Funds, and ancillary product Fees. The Fees payable by Customer under this Agreement will be adjusted through a credit to Customer's Fees in accordance with the guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees are effective for the period beginning January 1, 2026 through December 31, 2026 ("Guarantee Period"), unless otherwise specified. With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies under this Exhibit C.

These guarantees will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date this Agreement is signed by both parties. In the event these guarantees become effective later than the effective date of the Guarantee Period: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the Term of the Agreement during which this Agreement is signed by both parties.

United shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent its failure is due to Customer's actions or inactions or if United fails to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or United's required compliance with any law, regulation, or governmental agency mandate or anything beyond United's reasonable control.

Prior to the end of the Guarantee Period, and on the condition that this Agreement remains in force, United may specify to Customer in writing new performance guarantees for the subsequent Guarantee Period. If United specifies new performance guarantees, United will also provide Customer with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Claim Operations January 1, 2026 through December 31, 2026			
Time to Process in 10 Days			
Definition	The percentage of all claims United receives will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
Criteria	Standard claim operations reports		
Level	Site Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$40,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more		

Dollar Accuracy (DAR)			
Definition	Dollar accuracy rate of not less than the designated percent in any quarter.		
Measurement	Percentage of claims dollars processed accurately		99%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars paid.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$40,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	98.99% - 98.50% 98.49% - 98.00% 97.99% - 97.50% 97.49% - 97.00 Below 97.00%		
Procedural Accuracy			
Definition	Procedural accuracy rate of not less than the designated percent.		
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors		97%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.		
Level	Office Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$40,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%		
Member Phone Service			
Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Customer's Participants. If Customer elects a specialized phone service model the results may be blended with more than one call center and/or level. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy (except when United is Customer's pharmacy benefit services administrator), dental, vision, Health Savings Account, etc.			
Average Speed to Answer			
Definition	Calls will sequence through United's phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$40,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds		
Abandonment Rate			
Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		2%
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$40,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%

Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% Greater than 4.00%		
Call Quality Score			
Definition	Maintain a call quality score of not less than the percent set forth		
Measurement	Call quality score to meet or exceed		93%
Criteria	Random sampling of calls are each assigned a customer service quality score, using United's standard internal call quality assurance program.		
Level	Office that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$40,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%		
Satisfaction			
Employee (Member) Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads "Overall, how satisfied are you with the way we administers your medical health insurance plan?"		
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher		80%
Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.		
Level	Office that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$20,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Customer Satisfaction			
Definition	The overall satisfaction will be determined by the question that reads "How satisfied are you overall with UnitedHealthcare?"		
Measurement	Minimum score on a 10 point scale	score	5
Criteria	Standard Customer Scorecard Survey		
Level	Customer specific		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars Payable for this metric		$20,000
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		

In the event any of the terms herein are inconsistent with the requirements of any federal, state or other applicable law or regulation, then the inconsistent terms will be null and void and United will have the right to revise, reprice or revoke this arrangement.

Pharmacy Financials			
Definition	Pharmacy rate guarantees.		
Measurement and Criteria		**01/01/2026**	**01/01/2027**
	Component Discount Guarantee - Standard Select/WAG Network		
	Retail Brand, Average Wholesale Price (AWP) less	21.10%	21.10%
	Retail Generic, AWP less	87.70%	87.70%
	Mail Order Brand, AWP less	25.50%	25.50%
	Mail Order Generic, AWP less	87.85%	87.90%
	The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component.		
	Dispensing Fees - Standard Select/WAG Network		
	Retail Brand	$0.39	$0.39
	Retail Generic	$0.39	$0.39
	Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.		
	Minimum Rebate Guarantee		
	Rebate Sharing Percentage	95.0%	95.0%
	Basis, per script	Brand	Brand
	Retail - 30 and 90 Day	$417.95	$488.43
	Mail Order	$1,110.02	$1,313.11
	Specialty	$3,500.00	$3,718.34
	Fees		
	Variable Copay program (monthly, per eligible member)	$0.45	$0.45
Level	Customer Specific		
Period	Annually		
Payment Period	Annually		
Payment Amount -- Discounts	The amount the actual discounts are less than the guaranteed discount amount for each individual component.		
Payment Amount -- Dispensing Fees	The amount the combined actual dispensing fee exceeds the combined contracted dispensing fee.		
Payment Amount -- Rebates	The amount the combined actual Rebate amount is less than the combined guaranteed Rebate amount.		
Conditions	**Discount & Dispense Fee Specific Conditions** • Discounts are based on actual Network Pharmacy brand and generic usage of retail and mail order drugs. The guaranteed discount amount will be determined by multiplying the AWP by the contracted discount rate off AWP by component. • Does not apply to items covered under the Plan for which no AWP measure exists. • Discounts calculated based on AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail and mail order generic prescriptions represent the average AWP based on savings off Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • The following are excluded from the Discount Guarantee arrangement - Compound Drug claims - Retail out-of-network claims - Mail Order scripts (for dispense fee arrangement) - Indian Health Service claims - Usual & Customary (U&C) claims - Vaccine claims - Long Term Care (LTC) facility claims		

• Specialty drugs dispensed outside United's specialty Pharmacy Network are included in the retail discount and dispense fee guarantees. Specialty drugs dispensed through United's specialty Pharmacy Network are excluded from the Retail and Mail guarantees and included in the Specialty discount guarantee.

The following are included in the Discount Guarantee arrangement

- Claims where the plan is the secondary payer (COB claims)
- Veterans Affairs (VA) facility claims
- Over the Counter (OTC) claims

• The Mail Order guarantee includes drugs dispensed for 46 days or greater; claims with less than 46 days supply are reconciled at retail.
• When a drug is identified as a brand name drug, it will be considered a brand name drug for the calculation of discount guarantees. When a drug is identified as a generic drug, it will be considered a generic drug for the calculation of discount guarantees.

Rebate Specific Conditions

• Client directed deviations from the PDL and PDL exclusions or uptiers, or clinical programs may result in changes to pricing and guarantees, which will be factored in at the time of rebate payment and/or reconciliation.

• Calculation of the guaranteed rebate amount will exclude ineligible claims including:

- claims where the plan is not the primary payer (e.g., coordination of benefits and subrogation claims)
- claims approved by formulary exception
- claims not covered by Customer's benefit design or PDL
- claims receiving 340B pricing
- long term care pharmacy claims
- federal government pharmacy claims
- claims for non-FDA approved products
- compound drug claims
- direct member reimbursement claims

• Over-the-counter and repackaged drugs are excluded from the claim counts; Insulins are not excluded.
• Devices are excluded from the claim counts; Test Strips are not excluded.
• Multisource brand drugs are excluded from the claim counts.
• Vaccines are excluded from the claim counts.
• Rebate guarantee payments or reconciliations may be adjusted in the event of a change impacting the level of Rebates due to the utilization of therapeutically equivalent, lower Rebate drugs (e.g. biosimilar, authorized brand alternative, lower cost non-Generic Drug alternative) or the reduction of Wholesale Acquisition Cost on a Brand Drug subject to Rebates. In the event a payment or reconciliation adjustment is required, such adjustment will be based on the difference between a) pharmaceutical manufacturer revenue prior to the introduction of the lower Rebate drugs and b) the actual pharmaceutical manufacturer revenue received after the introduction of the lower Rebate drugs. Such adjustment does not apply to Generic Drugs that launch after the Brand Drug no longer has patent protection.
• The Rebate guarantees account for projected Rebate reductions in the following classes of Prescription Drugs in connection with the elimination of the Average Manufacturer's Price (AMP) Cap pursuant to the American Rescue Plan Act of 2021: Insulin products and Respiratory Medications. United reserves the right to modify any Rebate guarantees if there are any additional changes Specific to AMP Cap to Rebates received from pharmaceutical manufacturers.

United reserves the right to modify or eliminate this arrangement as follows based upon changes in Rebates:

• if changes made to United's PDL, for the purpose of achieving a lower net drug cost for Customer and United's other ASO customers, result in significant reductions to the Rebate level
• in the event that there are material deviations to the anticipated timing of drugs that will come off patent and no longer generate Rebates
• if there is a change impacting the availability or amount of Rebates offered by drug manufacturer(s), including changes related to the elimination or material modification of a drug manufacturer(s) historic models or practices related to the provision of Rebates

• United will pay Rebates consistent with the Agreement. A reconciliation of the Rebate amounts will occur after the end of each annual contract period and when Rebate payments are substantially complete. The reconciliation calculates the minimum rebate amount by multiplying the actual number of scripts filled by the applicable rebate amount for that script type.

• The Parties acknowledge and agree that United has priced the pharmacy benefit services under this Agreement in reliance on Customer's commitment to receive such services from United for the entire Pharmacy Pricing Term. In the event that Customer terminates pharmacy benefit services under this Agreement prior to the end of the Pharmacy Pricing Term, the following will apply:

- United will retain 100% of all pending and future Rebates payable under the Agreement as of the effective date of the termination of pharmacy benefit services and no reconciliation of minimum rebate guarantees will apply.

General Conditions

• All pricing guarantees shall remain in effect for the entire contract period of 01/01/2026 through 12/31/2027 ("Pharmacy Pricing Term"). Each twelve month period is a Guarantee Period.

• Specialty drugs typically covered under the medical benefit (administered / handled by a provider, administered in a physician's office, ambulatory or home infusion), and/or transitioned to the pharmacy benefit, are excluded from all guarantees.

• Drugs, products, supplies approved, covered and/or prescribed for the diagnosis, treatment or prevention of COVID-19 are excluded from all guarantees.

• On mail order drugs, specialty drugs, and retail pharmacy drugs and services including dispensing fees, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.

• Pricing and guarantees assume enrollment of 5,508 Employees and 10,819 Participants; pricing and guarantees may be revised or withdrawn if actual enrollment varies by 10% or more from assumptions.

• The lesser of three logic (non-ZBL) will apply to Participant payments. Participants pay the lesser of the discounted price, the usual and customary charge or the cost share amount.

• All pricing guarantees require the selection of United's PBM as exclusive provider of pharmacy benefit services, including but not limited to retail, mail order, and specialty networks.

United will have no financial guarantee obligation under the Agreement for any partial Guarantee Period if Customer terminates with an effective date prior to the end of the Pharmacy Pricing Term.

• In the event any of the terms herein is inconsistent with the requirements of any federal, state or other applicable law or regulation, then the inconsistent term(s) will be null and void and United will have the right to revise, reprice or revoke this arrangement.

• United reserves the right to revise or revoke this arrangement if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in these arrangements; c) Customer makes benefit changes that impact the arrangements; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark; e) it is not accepted within ninety (90) days of the issuance of our quote; f) if Customer changes their mail service benefit; g) Customer utilizes a vendor, that facilitates steering members to different drugs or pharmacies to the extent these services impact the financial guarantees under this Agreement.

Brand / Generic Reconciliation Definition

• **Brand Drug**: An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee , set forth in Medi-Span's National Drug Data File as a brand drug identified by all of the products meeting at least one of the following criteria:
- Medi-Span Multi-Source Code ("MSC") is equal to M, O, or N.

• **Generic Drug**: An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File as a generic drug identified by all products meeting at least one of the following criteria:
- Medi-Span Multi-Source Code ("MSC") is equal to Y.

Specialty Pharmacy			
Specialty Pharmacy Discount Guarantee			
Definition	Specialty drug discount level based on actual specialty drug utilization for the specialty drugs dispensed through United's specialty Pharmacy Network. United reserves the right to change the designation of a drug from specialty to non-specialty based on market conditions.		
Measurement	**Listed**	**01/01/2026**	**01/01/2027**
	All Include LDD	21.90%	21.90%
	Unlisted	**01/01/2026**	**01/01/2027**
	All Include LDD	14.00%	14.00%

Criteria	Actual utilization, using Average Wholesale Price (AWP) in dollars, using our data, of listed specialty drugs through Our specialty Pharmacy Network will be multiplied against the discount target to determine the overall discount target dollars.
	The overall discount target dollars may be adjusted based on utilization of unlisted drugs to which the separate unlisted discount applies. This total will be compared to actual discounts achieved for these drugs during the Guarantee Period.
Level	Customer Specific
Period	Annual
Payment Period	Annual
Payment Amount	The amount the combined actual specialty drug discounts are less than the composite discount drug target.
Conditions	• Discounts calculated based on the AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for generic
	prescriptions represent the average savings off AWP based on Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings
	off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP.
	• Specialty drugs dispensed outside United's specialty Pharmacy Network will be reconciled in the channel in which they are dispensed (retail or mail order).
	• Specialty drugs for which no AWP measure exists are excluded.
	• Listed drugs which cease to be defined as specialty drugs during the Guarantee Period will be reconciled outside of the Specialty Pharmacy guarantee in the channel in which they are dispensed (retail or mail order).
	• Limited Distribution (LDD) status is subject to change based on manufacturer decision.
	• Specialty drugs typically covered under the medical benefit (administered / handled by a provider, administered in a physician's office, ambulatory or home infusion), and/or transitioned to the pharmacy benefit, are excluded from all guarantees.
	• United reserves the right to revise or revoke this guarantee if:
	a) material changes in federal, state or other applicable law or regulation require modifications;
	b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in this guarantee;
	c) Customer makes benefit changes that impact the guarantee;
	d) there is a material industry change in pricing methodologies resulting in a new source or benchmark;
	• On specialty drugs, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.

Specialty Drug Category	Drug Name	LDD Indicator	Included/Excluded From Guarantee	Specialty Drug Category	Drug Name	LDD Indicator	Included/Excluded From Guarantee
AMMONIA DETOXICANTS	RAVICTI	Yes	Included	INFLAMMATORY CONDITIONS	KINERET	Yes	Included
ANEMIA	ARANESP	No	Included	INFLAMMATORY CONDITIONS	OLUMIANT	No	Included
ANEMIA	EPOGEN	No	Included	INFLAMMATORY CONDITIONS	OMVOH	No	Included
ANEMIA	JESDUVROQ	No	Included	INFLAMMATORY CONDITIONS	OPZELURA	No	Included
ANEMIA	PROCRIT	No	Included	INFLAMMATORY CONDITIONS	ORENCIA	No	Included
ANEMIA	RETACRIT	No	Included	INFLAMMATORY CONDITIONS	OTEZLA	No	Included
ANTIBACTERIALS	ARIKAYCE	Yes	Included	INFLAMMATORY CONDITIONS	RIDAURA	No	Included
ANTICONVULSANTS	DIACOMIT	Yes	Included	INFLAMMATORY CONDITIONS	RINVOQ	No	Included
ANTICONVULSANTS	EPIDIOLEX	Yes	Included	INFLAMMATORY CONDITIONS	SILIQ	No	Included
ANTICONVULSANTS	FINTEPLA	Yes	Included	INFLAMMATORY CONDITIONS	SIMLANDI	No	Included
ANTICONVULSANTS	ZTALMY	Yes	Included	INFLAMMATORY CONDITIONS	SIMPONI	No	Included
ANTIHYPERLIPIDEMIC	JUXTAPID	Yes	Included	INFLAMMATORY CONDITIONS	SKYRIZI	No	Included
ANTI-INFECTIVE	DARAPRIM	Yes	Included	INFLAMMATORY CONDITIONS	SOTYKTU	No	Included
ANTI-INFECTIVE	LIVTENCITY	Yes	Included	INFLAMMATORY CONDITIONS	SPEVIGO	Yes	Included

ANTI-INFECTIVE	PYRIMETHAMINE	No	Included	INFLAMMATORY CONDITIONS	STELARA	No	Included
ASTHMA	FASENRA	Yes	Included	INFLAMMATORY CONDITIONS	TALTZ	No	Included
ASTHMA	NUCALA	Yes	Included	INFLAMMATORY CONDITIONS	TREMFYA	No	Included
ASTHMA	TEZSPIRE	Yes	Included	INFLAMMATORY CONDITIONS	TYENNE	No	Included
ASTHMA	XOLAIR	Yes	Included	INFLAMMATORY CONDITIONS	VELSIPITY	No	Included
CARDIOVASCULAR	CAMZYOS	Yes	Included	INFLAMMATORY CONDITIONS	XELJANZ	No	Included
CARDIOVASCULAR	DROXIDOPA	No	Included	INFLAMMATORY CONDITIONS	XELJANZ XR	No	Included
CARDIOVASCULAR	NORTHERA	Yes	Included	INFLAMMATORY CONDITIONS	YUFLYMA	No	Included
CARDIOVASCULAR	VYNDAMAX	Yes	Included	INFLAMMATORY CONDITIONS	YUSIMRY	No	Included
CARDIOVASCULAR	VYNDAQEL	Yes	Included	INFLAMMATORY CONDITIONS	ZYMFENTRA	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	AUSTEDO	No	Included	IRON OVERLOAD	DEFERASIROX	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	ENSPRYNG	Yes	Included	IRON OVERLOAD	DEFERIPRONE	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	FIRDAPSE	Yes	Included	IRON OVERLOAD	EXJADE	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	HETLIOZ	Yes	Included	IRON OVERLOAD	FERRIPROX	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	INGREZZA	Yes	Included	IRON OVERLOAD	JADENU	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	RADICAVA	Yes	Included	LIVER DISEASE	REZDIFFRA	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	RILUZOLE	No	Included	METABOLIC AGENTS	MIPLYFFA	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	SABRIL	Yes	Included	METABOLIC BONE DISEASE	SOHONOS	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	SKYCLARYS	Yes	Included	MOOD DISORDER DRUGS	SPRAVATO	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	TASIMELTEON	Yes	Included	MOOD DISORDER DRUGS	ZURZUVAE	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	TEGLUTIK	Yes	Included	MULTIPLE SCLEROSIS	AMPYRA	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	TETRABENAZINE	No	Included	MULTIPLE SCLEROSIS	AUBAGIO	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	TIGLUTIK	Yes	Included	MULTIPLE SCLEROSIS	AVONEX	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	VIGABATRIN	No	Included	MULTIPLE SCLEROSIS	BAFIERTAM	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	VIGADRONE	Yes	Included	MULTIPLE SCLEROSIS	BETASERON	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	VIGPODER	Yes	Included	MULTIPLE SCLEROSIS	COPAXONE	No	Included

CENTRAL NERVOUS SYSTEM AGENTS	XENAZINE	Yes	Included	MULTIPLE SCLEROSIS	DALFAMPRIDIN	No	Included
CNS AGENTS	DAYBUE	Yes	Included	MULTIPLE SCLEROSIS	DIMETHYL FUMARATE	No	Included
CNS AGENTS	EXSERVAN	Yes	Included	MULTIPLE SCLEROSIS	EXTAVIA	No	Included
CNS AGENTS	RELYVRIO	Yes	Included	MULTIPLE SCLEROSIS	FINGOLIMOD	No	Included
CNS AGENTS	RILUTEK	No	Included	MULTIPLE SCLEROSIS	GILENYA	No	Included
CYSTIC FIBROSIS	BETHKIS	No	Included	MULTIPLE SCLEROSIS	GLATIRAMER	No	Included
CYSTIC FIBROSIS	BRONCHITOL	Yes	Included	MULTIPLE SCLEROSIS	GLATOPA	No	Included
CYSTIC FIBROSIS	CAYSTON	Yes	Included	MULTIPLE SCLEROSIS	KESIMPTA	No	Included
CYSTIC FIBROSIS	KALYDECO	Yes	Included	MULTIPLE SCLEROSIS	MAVENCLAD	Yes	Included
CYSTIC FIBROSIS	KITABIS PAK	Yes	Included	MULTIPLE SCLEROSIS	MAYZENT	No	Included
CYSTIC FIBROSIS	ORKAMBI	Yes	Included	MULTIPLE SCLEROSIS	PLEGRIDY	Yes	Included
CYSTIC FIBROSIS	PULMOZYME	No	Included	MULTIPLE SCLEROSIS	PONVORY	Yes	Included
CYSTIC FIBROSIS	SYMDEKO	Yes	Included	MULTIPLE SCLEROSIS	REBIF	No	Included
CYSTIC FIBROSIS	TOBI	No	Included	MULTIPLE SCLEROSIS	REBIF REBIDOSE	No	Included
CYSTIC FIBROSIS	TOBI PODHALER	No	Included	MULTIPLE SCLEROSIS	TASCENSO	Yes	Included
CYSTIC FIBROSIS	TOBRAMYCIN	No	Included	MULTIPLE SCLEROSIS	TECFIDERA	Yes	Included
CYSTIC FIBROSIS	TRIKAFTA	Yes	Included	MULTIPLE SCLEROSIS	TERIFLUNOMIDE	No	Included
DERMATOLOGIC	LITFULO	Yes	Included	MULTIPLE SCLEROSIS	VUMERITY	Yes	Included
DUCHENNE MUSCULAR DYSTROPHY	AGAMREE	Yes	Included	MULTIPLE SCLEROSIS	ZEPOSIA	Yes	Included
DUCHENNE MUSCULAR DYSTROPHY	DEFLAZACORT	No	Included	MUSCULOSKELETAL AGENTS	EVRYSDI	Yes	Included
DUCHENNE MUSCULAR DYSTROPHY	DUVYZAT	Yes	Included	MUSCULOSKELETAL AGENTS	VOXZOGO	Yes	Included
DUCHENNE MUSCULAR DYSTROPHY	EMFLAZA	Yes	Included	MUSCULOSKELETAL AGENTS	ZILBRYSQ	Yes	Included
ENDOCRINE	BETAINE	No	Included	MUSCULOSKELETAL DISORDERS	DICHLORPHENAMIDE	No	Included
ENDOCRINE	CHENODAL	Yes	Included	MUSCULOSKELETAL DISORDERS	KEVEYIS	Yes	Included
ENDOCRINE	CUPRIMINE	No	Included	NARCOLEPSY	LUMRYZ	Yes	Included
ENDOCRINE	CUVRIOR	Yes	Included	NARCOLEPSY	SODIUM OXYBATE	Yes	Included
ENDOCRINE	CYSTADANE	Yes	Included	NARCOLEPSY	WAKIX	Yes	Included
ENDOCRINE	DEPEN TITRATABS	No	Included	NARCOLEPSY	XYREM	Yes	Included
ENDOCRINE	EGRIFTA	Yes	Included	NARCOLEPSY	XYWAV	Yes	Included
ENDOCRINE	FIRMAGON	No	Included	NEUTROPENIA	FULPHILA	No	Included
ENDOCRINE	IMCIVREE	Yes	Included	NEUTROPENIA	FYLNETRA	No	Included
ENDOCRINE	ISTURISA	Yes	Included	NEUTROPENIA	GRANIX	No	Included
ENDOCRINE	JAVYGTOR	Yes	Included	NEUTROPENIA	LEUKINE	No	Included
ENDOCRINE	JYNARQUE	Yes	Included	NEUTROPENIA	NEULASTA	No	Included
ENDOCRINE	KORLYM	Yes	Included	NEUTROPENIA	NEUPOGEN	No	Included

ENDOCRINE	KUVAN	Yes	Included	NEUTROPENIA	NIVESTYM	No	Included
ENDOCRINE	LANREOTIDE	No	Included	NEUTROPENIA	NYVEPRIA	No	Included
ENDOCRINE	MIFEPRISTONE	Yes	Included	NEUTROPENIA	RELEUKO	No	Included
ENDOCRINE	MYALEPT	Yes	Included	NEUTROPENIA	STIMUFEND	No	Included
ENDOCRINE	MYCAPSSA	Yes	Included	NEUTROPENIA	UDENYCA	No	Included
ENDOCRINE	NATPARA	Yes	Included	NEUTROPENIA	ZARXIO	No	Included
ENDOCRINE	NITYR	Yes	Included	NEUTROPENIA	ZIEXTENZO	No	Included
ENDOCRINE	OCTREOTIDE ACETATE	No	Included	ONCOLOGY - INJECTABLE	BESREMI	Yes	Included
ENDOCRINE	PENICILLAMINE	No	Included	ONCOLOGY - INJECTABLE	ELIGARD	No	Included
ENDOCRINE	PROCYSBI	Yes	Included	ONCOLOGY - INJECTABLE	INTRON A	Yes	Included
ENDOCRINE	RECORLEV	Yes	Included	ONCOLOGY - INJECTABLE	LEUPROLIDE	No	Included
ENDOCRINE	SAMSCA	Yes	Included	ONCOLOGY - INJECTABLE	SYNRIBO	Yes	Included
ENDOCRINE	SANDOSTATIN	No	Included	ONCOLOGY - ORAL	ABIRATERONE	No	Included
ENDOCRINE	SAPROPTERIN	Yes	Included	ONCOLOGY - ORAL	AFINITOR	No	Included
ENDOCRINE	SIGNIFOR	Yes	Included	ONCOLOGY - ORAL	AFINITOR DISPERZ	No	Included
ENDOCRINE	SOMATULINE DEPOT	No	Included	ONCOLOGY - ORAL	AKEEGA	Yes	Included
ENDOCRINE	SOMAVERT	Yes	Included	ONCOLOGY - ORAL	ALECENSA	Yes	Included
ENDOCRINE	SYPRINE	No	Included	ONCOLOGY - ORAL	ALKERAN	No	Included
ENDOCRINE	THIOLA	Yes	Included	ONCOLOGY - ORAL	ALUNBRIG	Yes	Included
ENDOCRINE	TIOPRONIN	No	Included	ONCOLOGY - ORAL	AUGTYRO	No	Included
ENDOCRINE	TOLVAPTAN	No	Included	ONCOLOGY - ORAL	AYVAKIT	Yes	Included
ENDOCRINE	TRIENTINE	No	Included	ONCOLOGY - ORAL	BALVERSA	Yes	Included
ENDOCRINE	XURIDEN	Yes	Included	ONCOLOGY - ORAL	BEXAROTENE	No	Included
ENDOCRINE	YORVIPATH	Yes	Included	ONCOLOGY - ORAL	BOSULIF	Yes	Included
ENZYME DEFICIENCY	TEGSEDI	Yes	Included	ONCOLOGY - ORAL	BRAFTOVI	Yes	Included
ENZYME THERAPY	BUPHENYL	No	Included	ONCOLOGY - ORAL	BRUKINSA	Yes	Included
ENZYME THERAPY	CARBAGLU	Yes	Included	ONCOLOGY - ORAL	CABOMETYX	Yes	Included
ENZYME THERAPY	CARGLUMIC	Yes	Included	ONCOLOGY - ORAL	CALQUENCE	Yes	Included
ENZYME THERAPY	CERDELGA	Yes	Included	ONCOLOGY - ORAL	CAPECITABINE	No	Included
ENZYME THERAPY	CHOLBAM	Yes	Included	ONCOLOGY - ORAL	CAPRELSA	Yes	Included
ENZYME THERAPY	CYSTAGON	Yes	Included	ONCOLOGY - ORAL	COMETRIQ	Yes	Included
ENZYME THERAPY	GALAFOLD	Yes	Included	ONCOLOGY - ORAL	COPIKTRA	Yes	Included
ENZYME THERAPY	MIGLUSTAT	No	Included	ONCOLOGY - ORAL	COTELLIC	Yes	Included
ENZYME THERAPY	NITISINONE	No	Included	ONCOLOGY - ORAL	DASATINIB	No	Included
ENZYME THERAPY	OLPRUVA	Yes	Included	ONCOLOGY - ORAL	DAURISMO	Yes	Included
ENZYME THERAPY	OPFOLDA	Yes	Included	ONCOLOGY - ORAL	ERIVEDGE	Yes	Included

ENZYME THERAPY	ORFADIN	Yes	Included	ONCOLOGY - ORAL	ERLEADA	No	Included
ENZYME THERAPY	PALYNZIQ	Yes	Included	ONCOLOGY - ORAL	ERLOTINIB	Yes	Included
ENZYME THERAPY	PHEBURANE	Yes	Included	ONCOLOGY - ORAL	ETOPOSIDE	No	Included
ENZYME THERAPY	SODIUM PHENYLBUTYRATE	No	Included	ONCOLOGY - ORAL	EVEROLIMUS	No	Included
ENZYME THERAPY	STRENSIQ	Yes	Included	ONCOLOGY - ORAL	EXKIVITY	Yes	Included
ENZYME THERAPY	SUCRAID	Yes	Included	ONCOLOGY - ORAL	FARYDAK	Yes	Included
ENZYME THERAPY	WAINUA	Yes	Included	ONCOLOGY - ORAL	FOTIVDA	Yes	Included
ENZYME THERAPY	YARGESA	Yes	Included	ONCOLOGY - ORAL	FRUZAQLA	Yes	Included
ENZYME THERAPY	ZAVESCA	Yes	Included	ONCOLOGY - ORAL	GAVRETO	Yes	Included
GASTROINTESTINAL AGENTS	GATTEX	Yes	Included	ONCOLOGY - ORAL	GEFITINIB	No	Included
GASTROINTESTINAL AGENTS	IQIRVO	Yes	Included	ONCOLOGY - ORAL	GILOTRIF	Yes	Included
GASTROINTESTINAL AGENTS	LIVDELZI	Yes	Included	ONCOLOGY - ORAL	GLEEVEC	No	Included
GASTROINTESTINAL AGENTS	OCALIVA	Yes	Included	ONCOLOGY - ORAL	GLEOSTINE	No	Included
GASTROINTESTINAL AGENTS	VOWST	Yes	Included	ONCOLOGY - ORAL	HYCAMTIN	No	Included
GASTROINTESTINAL AGENTS	XERMELO	Yes	Included	ONCOLOGY - ORAL	IBRANCE	Yes	Included
GENETIC DISORDER	DOJOLVI	Yes	Included	ONCOLOGY - ORAL	ICLUSIG	Yes	Included
GENETIC DISORDER	VIJOICE	No	Included	ONCOLOGY - ORAL	IDHIFA	No	Included
GENETIC DISORDER	ZOKINVY	Yes	Included	ONCOLOGY - ORAL	IMATINIB MESYLATE	No	Included
GROWTH HORMONE DEFICIENCY	GENOTROPIN	No	Included	ONCOLOGY - ORAL	IMBRUVICA	Yes	Included
GROWTH HORMONE DEFICIENCY	HUMATROPE	No	Included	ONCOLOGY - ORAL	INLYTA	Yes	Included
GROWTH HORMONE DEFICIENCY	INCRELEX	Yes	Included	ONCOLOGY - ORAL	INQOVI	Yes	Included
GROWTH HORMONE DEFICIENCY	NGENLA	No	Included	ONCOLOGY - ORAL	INREBIC	Yes	Included
GROWTH HORMONE DEFICIENCY	NORDITROPIN	No	Included	ONCOLOGY - ORAL	IRESSA	Yes	Included
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	No	Included	ONCOLOGY - ORAL	IWILFIN	Yes	Included
GROWTH HORMONE DEFICIENCY	OMNITROPE	No	Included	ONCOLOGY - ORAL	JAKAFI	Yes	Included
GROWTH HORMONE DEFICIENCY	SAIZEN	No	Included	ONCOLOGY - ORAL	JAYPIRCA	Yes	Included
GROWTH HORMONE DEFICIENCY	SEROSTIM	No	Included	ONCOLOGY - ORAL	KISQALI	No	Included
GROWTH HORMONE DEFICIENCY	SKYTROFA	No	Included	ONCOLOGY - ORAL	KISQALI FEMARA	No	Included

GROWTH HORMONE DEFICIENCY	SOGROYA	No	Included	ONCOLOGY - ORAL	KOSELUGO	Yes	Included
GROWTH HORMONE DEFICIENCY	ZOMACTON	No	Included	ONCOLOGY - ORAL	KRAZATI	Yes	Included
GROWTH HORMONE DEFICIENCY	ZORBTIVE	Yes	Included	ONCOLOGY - ORAL	LAPATINIB	No	Included
HEMATOLOGIC	OXBRYTA	Yes	Included	ONCOLOGY - ORAL	LENALIDOMIDE	Yes	Included
HEMATOLOGICAL AGENTS	CABLIVI	Yes	Included	ONCOLOGY - ORAL	LENVIMA	Yes	Included
HEMATOLOGICAL AGENTS	DOPTELET	Yes	Included	ONCOLOGY - ORAL	LONSURF	Yes	Included
HEMATOLOGICAL AGENTS	EMPAVELI	Yes	Included	ONCOLOGY - ORAL	LORBRENA	Yes	Included
HEMATOLOGICAL AGENTS	FABHALTA	Yes	Included	ONCOLOGY - ORAL	LUMAKRAS	Yes	Included
HEMATOLOGICAL AGENTS	MOZOBIL	No	Included	ONCOLOGY - ORAL	LYNPARZA	Yes	Included
HEMATOLOGICAL AGENTS	MULPLETA	No	Included	ONCOLOGY - ORAL	LYTGOBI	Yes	Included
HEMATOLOGICAL AGENTS	PLERIXAFOR	No	Included	ONCOLOGY - ORAL	MATULANE	Yes	Included
HEMATOLOGICAL AGENTS	PROMACTA	No	Included	ONCOLOGY - ORAL	MEKINIST	No	Included
HEMATOLOGICAL AGENTS	PYRUKYND	Yes	Included	ONCOLOGY - ORAL	MEKTOVI	Yes	Included
HEMATOLOGICAL AGENTS	REZUROCK	Yes	Included	ONCOLOGY - ORAL	MELPHALAN	No	Included
HEMATOLOGICAL AGENTS	TAVALISSE	Yes	Included	ONCOLOGY - ORAL	MESNEX	No	Included
HEMOPHILIA - INFUSED	ADVATE	No	Included	ONCOLOGY - ORAL	NERLYNX	Yes	Included
HEMOPHILIA - INFUSED	ADYNOVATE	No	Included	ONCOLOGY - ORAL	NEXAVAR	Yes	Included
HEMOPHILIA - INFUSED	AFSTYLA	No	Included	ONCOLOGY - ORAL	NILANDRON	No	Included
HEMOPHILIA - INFUSED	ALPHANATE/VON WILLEBRAND	No	Included	ONCOLOGY - ORAL	NILUTAMIDE	No	Included
HEMOPHILIA - INFUSED	ALPHANINE SD	No	Included	ONCOLOGY - ORAL	NINLARO	No	Included
HEMOPHILIA - INFUSED	ALPROLIX	No	Included	ONCOLOGY - ORAL	NUBEQA	Yes	Included
HEMOPHILIA - INFUSED	ALTUVIIIO	No	Included	ONCOLOGY - ORAL	ODOMZO	No	Included
HEMOPHILIA - INFUSED	BENEFIX	No	Included	ONCOLOGY - ORAL	OGSIVEO	Yes	Included
HEMOPHILIA - INFUSED	COAGADEX	Yes	Included	ONCOLOGY - ORAL	OJEMDA	Yes	Included
HEMOPHILIA - INFUSED	CORIFACT	No	Included	ONCOLOGY - ORAL	OJJAARA	Yes	Included
HEMOPHILIA - INFUSED	ELOCTATE	No	Included	ONCOLOGY - ORAL	ONUREG	No	Included
HEMOPHILIA - INFUSED	ESPEROCT	No	Included	ONCOLOGY - ORAL	ORGOVYX	Yes	Included
HEMOPHILIA - INFUSED	FEIBA	No	Included	ONCOLOGY - ORAL	ORSERDU	Yes	Included
HEMOPHILIA - INFUSED	HEMOFIL M	No	Included	ONCOLOGY - ORAL	PAZOPANIB	Yes	Included
HEMOPHILIA - INFUSED	HUMATE-P	No	Included	ONCOLOGY - ORAL	PEMAZYRE	Yes	Included
HEMOPHILIA - INFUSED	IDELVION	No	Included	ONCOLOGY - ORAL	PIQRAY	No	Included
HEMOPHILIA - INFUSED	IXINITY	No	Included	ONCOLOGY - ORAL	POMALYST	Yes	Included

HEMOPHILIA - INFUSED	JIVI	No	Included	ONCOLOGY - ORAL	PURIXAN	No	Included
HEMOPHILIA - INFUSED	KOATE	No	Included	ONCOLOGY - ORAL	QINLOCK	Yes	Included
HEMOPHILIA - INFUSED	KOATE-DVI	No	Included	ONCOLOGY - ORAL	RETEVMO	Yes	Included
HEMOPHILIA - INFUSED	KOGENATE FS	No	Included	ONCOLOGY - ORAL	REVLIMID	Yes	Included
HEMOPHILIA - INFUSED	KOVALTRY	No	Included	ONCOLOGY - ORAL	REZLIDHIA	Yes	Included
HEMOPHILIA - INFUSED	MONONINE	No	Included	ONCOLOGY - ORAL	ROZLYTREK	No	Included
HEMOPHILIA - INFUSED	NOVOEIGHT	No	Included	ONCOLOGY - ORAL	RUBRACA	Yes	Included
HEMOPHILIA - INFUSED	NOVOSEVEN RT	No	Included	ONCOLOGY - ORAL	RYDAPT	No	Included
HEMOPHILIA - INFUSED	NUWIQ	No	Included	ONCOLOGY - ORAL	SCEMBLIX	Yes	Included
HEMOPHILIA - INFUSED	OBIZUR	No	Included	ONCOLOGY - ORAL	SORAFENIB	No	Included
HEMOPHILIA - INFUSED	PROFILNINE	No	Included	ONCOLOGY - ORAL	SPRYCEL	No	Included
HEMOPHILIA - INFUSED	REBINYN	No	Included	ONCOLOGY - ORAL	STIVARGA	Yes	Included
HEMOPHILIA - INFUSED	RECOMBINATE	No	Included	ONCOLOGY - ORAL	SUNITINIB	Yes	Included
HEMOPHILIA - INFUSED	RIXUBIS	No	Included	ONCOLOGY - ORAL	SUTENT	Yes	Included
HEMOPHILIA - INFUSED	SEVENFACT	No	Included	ONCOLOGY - ORAL	TABLOID	No	Included
HEMOPHILIA - INFUSED	TRETTEN	Yes	Included	ONCOLOGY - ORAL	TABRECTA	No	Included
HEMOPHILIA - INFUSED	VONVENDI	Yes	Included	ONCOLOGY - ORAL	TAFINLAR	No	Included
HEMOPHILIA - INFUSED	WILATE	No	Included	ONCOLOGY - ORAL	TAGRISSO	Yes	Included
HEMOPHILIA - INFUSED	XYNTHA	No	Included	ONCOLOGY - ORAL	TALZENNA	Yes	Included
HEMOPHILIA - INJECTABLE	HEMLIBRA	Yes	Included	ONCOLOGY - ORAL	TARCEVA	Yes	Included
HEPATITIS C	EPCLUSA	No	Included	ONCOLOGY - ORAL	TARGRETIN	No	Included
HEPATITIS C	HARVONI	No	Included	ONCOLOGY - ORAL	TASIGNA	Yes	Included
HEPATITIS C	LEDIPASVIR/SOFOSBUVIR	No	Included	ONCOLOGY - ORAL	TAZVERIK	Yes	Included
HEPATITIS C	MAVYRET	No	Included	ONCOLOGY - ORAL	TEMODAR	No	Included
HEPATITIS C	PEGASYS	No	Included	ONCOLOGY - ORAL	TEMOZOLOMIDE	No	Included
HEPATITIS C	SOFOSBUVIR/VELPATASVIR	No	Included	ONCOLOGY - ORAL	TEPMETKO	Yes	Included
HEPATITIS C	SOVALDI	No	Included	ONCOLOGY - ORAL	THALOMID	Yes	Included
HEPATITIS C	VIEKIRA PAK	No	Included	ONCOLOGY - ORAL	TIBSOVO	Yes	Included
HEPATITIS C	VOSEVI	No	Included	ONCOLOGY - ORAL	TORPENZ	Yes	Included
HEPATITIS C	ZEPATIER	No	Included	ONCOLOGY - ORAL	TRETINOIN	No	Included
HEPATOLOGY	BYLVAY	Yes	Included	ONCOLOGY - ORAL	TRUQAP	Yes	Included
HEPATOLOGY	LIVMARLI	Yes	Included	ONCOLOGY - ORAL	TRUSELTIQ	Yes	Included
HEREDITARY ANGIOEDEMA	BERINERT	Yes	Included	ONCOLOGY - ORAL	TUKYSA	Yes	Included

HEREDITARY ANGIOEDEMA	CINRYZE	Yes	Included	ONCOLOGY - ORAL	TURALIO	Yes	Included
HEREDITARY ANGIOEDEMA	FIRAZYR	Yes	Included	ONCOLOGY - ORAL	TYKERB	No	Included
HEREDITARY ANGIOEDEMA	HAEGARDA	Yes	Included	ONCOLOGY - ORAL	VANFLYTA	Yes	Included
HEREDITARY ANGIOEDEMA	ICATIBANT	No	Included	ONCOLOGY - ORAL	VENCLEXTA	Yes	Included
HEREDITARY ANGIOEDEMA	ORLADEYO	Yes	Included	ONCOLOGY - ORAL	VERZENIO	Yes	Included
HEREDITARY ANGIOEDEMA	RUCONEST	Yes	Included	ONCOLOGY - ORAL	VITRAKVI	Yes	Included
HEREDITARY ANGIOEDEMA	SAJAZIR	Yes	Included	ONCOLOGY - ORAL	VIZIMPRO	Yes	Included
HEREDITARY ANGIOEDEMA	TAKHZYRO	Yes	Included	ONCOLOGY - ORAL	VONJO	Yes	Included
IGA NEPHROPATHY	FILSPARI	Yes	Included	ONCOLOGY - ORAL	VOTRIENT	Yes	Included
IGA NEPHROPATHY	TARPEYO	Yes	Included	ONCOLOGY - ORAL	WELIREG	Yes	Included
IMMUNOLOGICAL AGENTS	ACTIMMUNE	Yes	Included	ONCOLOGY - ORAL	XALKORI	Yes	Included
IMMUNOLOGICAL AGENTS	ARCALYST	Yes	Included	ONCOLOGY - ORAL	XELODA	No	Included
IMMUNOLOGICAL AGENTS	BENLYSTA	Yes	Included	ONCOLOGY - ORAL	XOSPATA	Yes	Included
IMMUNOLOGICAL AGENTS	JOENJA	Yes	Included	ONCOLOGY - ORAL	XPOVIO	Yes	Included
IMMUNOLOGICAL AGENTS	LUPKYNIS	Yes	Included	ONCOLOGY - ORAL	XTANDI	Yes	Included
IMMUNOLOGICAL AGENTS	PALFORZIA	Yes	Included	ONCOLOGY - ORAL	YONSA	No	Included
IMMUNOLOGICAL AGENTS	TAVNEOS	Yes	Included	ONCOLOGY - ORAL	ZEJULA	Yes	Included
IMMUNOLOGICAL AGENTS	XOLREMDI	Yes	Included	ONCOLOGY - ORAL	ZELBORAF	Yes	Included
INFERTILITY	CETRORELIX	No	Included	ONCOLOGY - ORAL	ZOLINZA	No	Included
INFERTILITY	CETROTIDE	No	Included	ONCOLOGY - ORAL	ZYDELIG	Yes	Included
INFERTILITY	CHORIONIC GONADOTROPIN	No	Included	ONCOLOGY - ORAL	ZYKADIA	Yes	Included
INFERTILITY	FOLLISTIM AQ	No	Included	ONCOLOGY - ORAL	ZYTIGA	No	Included
INFERTILITY	FYREMADEL	No	Included	ONCOLOGY - TOPICAL	BEXAROTENE	No	Included
INFERTILITY	GANIRELIX ACETATE	No	Included	ONCOLOGY - TOPICAL	TARGRETIN	No	Included
INFERTILITY	GONAL-F	No	Included	ONCOLOGY - TOPICAL	VALCHLOR	Yes	Included
INFERTILITY	GONAL-F RFF	No	Included	OPHTHALMIC AGENTS	CYSTADROPS	Yes	Included
INFERTILITY	MENOPUR	No	Included	OPHTHALMIC AGENTS	CYSTARAN	Yes	Included
INFERTILITY	NOVAREL	No	Included	OPHTHALMIC AGENTS	OXERVATE	Yes	Included
INFERTILITY	OVIDREL	No	Included	OSTEOPOROSIS	FORTEO	No	Included
INFERTILITY	PREGNYL	No	Included	OSTEOPOROSIS	TERIPARATIDE	No	Included
INFLAMMATORY CONDITIONS	ABRILADA	No	Included	OSTEOPOROSIS	TYMLOS	No	Included
INFLAMMATORY CONDITIONS	ACTEMRA	No	Included	PARKINSONS DISEASE	KYNMOBI	No	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-AACF	No	Included	PARKINSON'S DISEASE	APOKYN	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-AATY	No	Included	PARKINSON'S DISEASE	APOMORPHINE	Yes	Included

INFLAMMATORY CONDITIONS	ADALIMUMAB-ADAZ	No	Included	PARKINSON'S DISEASE	INBRIJA	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-ADBM	No	Included	PULMONARY FIBROSIS	ESBRIET	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-FKJP	No	Included	PULMONARY FIBROSIS	OFEV	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-RYVK	No	Included	PULMONARY FIBROSIS	PIRFENIDONE	No	Included
INFLAMMATORY CONDITIONS	ADBRY	Yes	Included	PULMONARY HYPERTENSION	ADCIRCA	No	Included
INFLAMMATORY CONDITIONS	AMJEVITA	No	Included	PULMONARY HYPERTENSION	ADEMPAS	Yes	Included
INFLAMMATORY CONDITIONS	BIMZELX	No	Included	PULMONARY HYPERTENSION	ALYQ	No	Included
INFLAMMATORY CONDITIONS	CIBINQO	No	Included	PULMONARY HYPERTENSION	AMBRISENTAN	Yes	Included
INFLAMMATORY CONDITIONS	CIMZIA	No	Included	PULMONARY HYPERTENSION	BOSENTAN	Yes	Included
INFLAMMATORY CONDITIONS	CORTROPHIN	Yes	Included	PULMONARY HYPERTENSION	LETAIRIS	Yes	Included
INFLAMMATORY CONDITIONS	COSENTYX	No	Included	PULMONARY HYPERTENSION	LIQREV	Yes	Included
INFLAMMATORY CONDITIONS	CYLTEZO	No	Included	PULMONARY HYPERTENSION	OPSUMIT	Yes	Included
INFLAMMATORY CONDITIONS	DUPIXENT	No	Included	PULMONARY HYPERTENSION	ORENITRAM	Yes	Included
INFLAMMATORY CONDITIONS	EBGLYSS	No	Included	PULMONARY HYPERTENSION	REVATIO	No	Included
INFLAMMATORY CONDITIONS	ENBREL	No	Included	PULMONARY HYPERTENSION	SILDENAFIL	No	Included
INFLAMMATORY CONDITIONS	ENTYVIO	No	Included	PULMONARY HYPERTENSION	TADALAFIL	No	Included
INFLAMMATORY CONDITIONS	H.P. ACTHAR	Yes	Included	PULMONARY HYPERTENSION	TADLIQ	Yes	Included
INFLAMMATORY CONDITIONS	HADLIMA	No	Included	PULMONARY HYPERTENSION	TRACLEER	Yes	Included
INFLAMMATORY CONDITIONS	HULIO	No	Included	PULMONARY HYPERTENSION	TYVASO	Yes	Included
INFLAMMATORY CONDITIONS	HUMIRA	No	Included	PULMONARY HYPERTENSION	UPTRAVI	Yes	Included
INFLAMMATORY CONDITIONS	HYRIMOZ	No	Included	PULMONARY HYPERTENSION	VENTAVIS*	Yes	Included
INFLAMMATORY CONDITIONS	IDACIO	No	Included	PULMONARY HYPERTENSION	WINREVAIR	Yes	Included
INFLAMMATORY CONDITIONS	ILUMYA	No	Included	WOUND MANAGEMENT	FILSUVEZ	Yes	Included
INFLAMMATORY CONDITIONS	KEVZARA	No	Included				

*Includes Nebulizer

EXHIBIT A-3.1

2026 UPDATES TO STOP LOSS POLICY IN EXHIBIT A-3

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-877-294-1429

AMENDMENT NO. 6

Amendment to be attached to and made a part of Group Policy No. GA-717340AL, issued by UnitedHealthcare Insurance Company (herein called "Company") to City and County of Denver (herein called "Policyholder").

It is agreed by and between the Company and the Policyholder that

1. The page entitled "Schedule Of Benefits" as contained in the Policy is hereby replaced with the attached page entitled "Schedule Of Benefits".
2. This Amendment will hereby be effective as of January 1, 2026.

UnitedHealthcare Insurance Company

Jessica Paik, President

Tracy A. Amey, Secretary

ACCEPTED BY: _____

Title: _____

Date: _____

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-877-294-1429

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder:	City and County of Denver
Policy Number:	GA-717340 AL
Original Effective Date:	January 1, 2020
Subsequent Policy Period Effective Date:	January 1, 2027
Administrator:	United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2026 through December 31, 2026, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2020 through December 31, 2026 and Paid from January 1, 2026 through December 31, 2026.

Specific Deductible per Covered Person: $450,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: Unlimited

Specific Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Specific Excess Loss Premium: $74.94 per subscriber per month

AGGREGATE EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2020 through December 31, 2026 and Paid from January 1, 2026 through December 31, 2026.

Aggregate Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: $2,000,000 per policy year

Minimum Annual Aggregate Deductible: $126,427,884 or 95% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $450,000

Monthly Aggregate Factors: $2,013.47 per subscriber

Aggregate Excess Loss Premium: $2.62 per subscriber per month

EXHIBIT A-4.1

SELF-FUNDED BENEFITS PLAN

2026 UPDATED EAP ADMINISTRATIVE SERVICES AGREEMENT

United Behavioral Health

FINANCIAL RENEWAL AND TERMS AMENDMENT

This Amendment ("Amendment") is made to the Master Purchase Agreement ("Agreement") by and between United HealthCare Services, Inc. ("United") and City and County of Denver ("Customer"), Contract No. 717340, and is effective on January 1, 2026 unless otherwise specified.

Any capitalized terms used in this Amendment have the meanings shown in the Agreement. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

The agreements that are being amended include any and all amendments, if any, that are effective prior to the effective date of this Amendment.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the agreements other than as stated herein.

The parties, by signing below, agree to amend the agreements as contained herein.

City and County of Denver	**United Behavioral Health**
By _____	By _____
Authorized Signature	Authorized Signature
Print Name _____	Print Name _____
Print Title _____	Print Title _____
Date _____	Date _____

EXHIBIT A
to
EAP AGREEMENT

The following financial terms are effective for the period January 1, 2026 through December 31, 2026, unless otherwise specified.

SERVICES AND FEES

The following are the administrative services Optum has agreed to provide to City at the rates set forth herein.

Base Program Offering	Year 1	Year 2 (estimated)[1]	Fee Basis	Annual Total
Emotional Wellbeing	$17,798.00	$18,242.95	Monthly Fee	$213,576
Emotional Wellbeing Solutions - EWS - EMPLOYER	$19,913.00	$20,410.83	Monthly Fee	$238,956
Subtotal - Emotional Wellbeing				$452,532
Total Fees				$452,532

[1] (Footnote 1)

Population	Total	Non-UHC
Employees	14,000	14,000
Members	30,800	30,800
ACS	2.20	2.20

Footnotes

Description

1 In the event of a conflict between the terms described in the accompanying proposal (including any and all attachments, oral discussions, and subsequent amendments) and the terms of this Exhibit, the terms of this Exhibit shall control. This pricing assumes the explicit Population and Demographic parameters displayed in the table above

{table shows employees/subscribers, members, ACS}. These parameters are reflective of our understanding of this population as of the date of this quote. If any of these parameters change by more than 10%, the fees and annual estimates may need to be recalculated.

All rates increase annually by the greater of 2.5% or the year-over-year change in the Employment Cost Index,

Healthcare and Social Assistance, Private Employers as published by the Bureau of Labor Statistics for the most recently available period.

2 Dedicated Workplace Support (DWS)/Onsite EAP rates are based on hours per week per site and to be paid as monthly lump sum. Rates reflect standard work hours and do not include any shift differential pay. If the contracted number of hours at any site changes, then pricing will be revised accordingly.

DWS/Onsite EAP services provided at one location unless otherwise mutually agreed upon. Travel and/or incidental costs (if applicable) will be billed outside of quoted monthly fee. DWS/Onsite EAP is valid only with the purchase or continuation of the Emotional Wellbeing (FKA EAP) program in place with Optum.

DWS/Onsite EAP pricing is based on comparable cost levels in the proposed geographical locations and is subject to change if specific salary requirements apply. Customer provides the necessary office furniture and confidential space for Dedicated consultant.

Dedicated Consultants are employees of Optum and are hired per the hiring policies of Optum, including paid time off, sick days and

FMLA/Family Leave. Dedicated Consultant attendance subject to the policies of Optum and Dedicated Consultants are entitled to take paid time off ("PTO"), sick days and FMLA/Family Leave. Monthly fees shall not be reduced by the number of holiday, PTO and sick days used by the Dedicated Consultant(s).

If a Dedicated Consultant requests to take FMLA/Family Leave, Optum and Customer will work together in good faith to either replace the Dedicated Consultant during their FMLA/Family leave and/or adjust pricing as mutually agreed.

In the event that Customer reasonably determines that a EWS Consultant is not adequately performing their major job responsibilities, Customer agrees to immediately notify Optum's onsite leadership team in writing (email is acceptable) of their concerns. Upon Optum's receipt of written notification, the parties will then work together in good faith to resolve such potential issue(s) within a mutually agreed upon timeframe.

If, upon expiration of the mutually agreed upon timeframe, Customer reasonably determines that the EWS Consultant's performance has not improved to the performance standard mutually agreed upon by the parties, Optum will replace the DWS Consultant at Customer's written request.

DWS/Onsite EAP services consists of the following:

- DWS/Onsite EAP consultations: Provide consultations and referrals to services as appropriate. This may include an initial assessment and subsequent conversations to address short-term, solution-focused approaches to addressing an employee primary presenting issues or referral into other appropriate services for further support. As available and in certain instances, DWS/Onsite EAP Dedicated Consultants may perform services virtually, as mutually agreed upon, thereby extending the reach of the Dedicated Consultant's beyond a specific job site.
- Management consultations: Consultations with managers/supervisor or human resource representatives regarding an employee's work-related issue(s) impacting performance or issues impacting the entire organization.
- Critical Incident Response Service: Dedicated consultants may provide individual or group virtual or in person support options during their normal work hours or as mutually agreed upon.
- Mental Health and Wellbeing Trainings: Dedicated consultants may deliver scheduled in person or virtual trainings from the Optum catalogue to address wellness, performance, work-life balance and more.
- Onsite EAP Utilization Report: Provided quarterly.
- Scheduling tool: Electronic-based scheduling tool for employees to access and self-schedule appts.

Pricing excludes all control reporting and customer audit functions. Pricing is net of broker commissions.

EXHIBIT A-5

2026 CHOICE DOCTORS PLAN

SUMMARY OF BENEFTS AND COVERAGE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-842-5520 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$500** Individual / **$1,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$4,500** Individual / **$9,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-**800-842-5520 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	Virtual visits - No Charge by a Designated Virtual Network Provider. *Cost share applies to any other Telehealth service based on provider type.
	Specialist visit	$75 copay per visit, deductible does not apply.	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay per service, deductible does not apply.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$250 copay per service, deductible does not apply.	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	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. *or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: $35 copay, deductible does not apply. Mail-Order: $87.50 copay, deductible does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $60 copay, deductible does not apply. Mail-Order: $150 copay, deductible does not apply.	Not Covered	
	Tier 4 – Your Highest Cost Option	Retail: $100 copay, deductible does not apply. Mail-Order: $250 copay, deductible does not apply.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	Network Partial hospitalization/intensive outpatient treatment: No Charge
	Inpatient services	20% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$75 copay per visit, deductible does not apply.	Not Covered	Limits per calendar year: Physical, Speech, Occupational combined 60 visits; Pulmonary: 20 visits; Cardiac: 36 visits
	Habilitative services	$75 copay per visit, deductible does not apply.	Not Covered	Services are provided under and limits are combined with Rehabilitation Services above.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	Durable medical equipment	20% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice services	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$50 copay per visit, deductible does not apply.	Not Covered	Limited to 1 exam every 24 months.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Glasses
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture – 20 visits per calendar year
- Bariatric surgery
- Chiropractic (Manipulative care) – 20 visits per calendar year
- Hearing aids - $1,000 per 36 months
- Infertility treatment
- Routine eye care (adult) - 1 exam per 24 months

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-842-5520.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-842-5520.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-842-5520.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-842-5520 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-842-5520.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-842-5520.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-842-5520.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-842-5520.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copay	$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$30
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,790**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copay	$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,100
Coinsurance	$60
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,690**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

EXHIBIT A-6

2026 HSA CHOICE PLUS PLAN

SUMMARY OF BENEFITS AND COVERAGE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-842-5520.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $**1,700** Individual / **$3,400** Family Out-of-Network: **$3,300** Individual / **$6,600** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$3,300** Individual / **$6,600** Family Out-of-Network: **$6,600** Individual / **$13,200** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-800-842-5520** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Virtual visits - 20% coinsurance by a Designated Virtual Network Provider. *Cost share applies to any other Telehealth service based on provider type.No virtual coverage out-of-network
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No coverage out-of-network
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or a $50 penalty applies.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay Mail-Order: $25 copay	Retail: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply. *or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit
	Tier 2 – Your Mid-Range Cost Option	Retail: $35 copay Mail-Order: $87.50 copay	Retail: $35 copay	
	Tier 3 – Your Mid-Range Cost Option	Retail: $60 copay Mail-Order: $150 copay	Retail: $60 copay	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	*20% coinsurance	*Network deductible applies
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or a $50 penalty applies.
If you are pregnant	Office visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or a $50 penalty applies.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: combined 60; Pulmonary: 20 visits. Cardiac: 36 visits.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitative services	20% coinsurance	50% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required out-of-network for certain services or a $50 penalty applies.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or a $50 penalty applies.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or a $50 penalty applies.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	50% coinsurance	Limited to 1 exam every 24 months.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Glasses
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture – 20 visits per calendar year
- Bariatric surgery
- Infertility Treatment
- Chiropractic (Manipulative care) – 20 visits per calendar year
- Hearing aids - $1,000 per 36 years months
- Routine eye care (adult) - 1 exam per 24 months

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform..

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-842-5520.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-842-5520.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-842-5520.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-842-5520 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-842-5520.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-842-5520.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-842-5520.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-842-5520.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$700
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,490**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,700**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,600**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

EXHIBIT A-7

2026 CHOICE PLAN DENVER HEALTH PPO

SUMMARY OF BENEFITS AND COVERAGE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-842-5520 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 Network: **$250** Individual / **$500** Family Tier 2 Network: **$1,250** Individual / **$2,500** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 Network: **$5,000** Individual / **$10,000** Family Tier 2 Network: **$5,000** Individual / **$10,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call 1-800-842-5520 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit, deductible does not apply.	20% coinsurance	Not Covered	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider. *Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$30 copay per visit, deductible does not apply.	20% coinsurance	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: 10% coinsurance X-Ray/Diagnostic: 10% coinsurance	Lab Testing: 20% coinsurance X-Ray/Diagnostic: 20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	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. *or Preferred 90 Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 – Your Mid-Range Cost Option	Retail: $35 copay, deductible does not apply. Mail-Order: $87.50 copay, deductible does not apply.	Retail: $35 copay, deductible does not apply. Mail-Order: $87.50 copay, deductible does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $60 copay, deductible does not apply. Mail-Order: $150 copay, deductible does not apply.	Retail: $60 copay, deductible does not apply. Mail-Order: $150 copay, deductible does not apply.	Not Covered	
	Tier 4 – Your Highest Cost Option	Retail: $100 copay, deductible does not apply. Mail-Order: $250 copay, deductible does not apply.	Retail: $100 copay, deductible does not apply. Mail-Order: $250 copay, deductible does not apply.	Not Applicable	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay per visit, deductible does not apply.	20% coinsurance	Not Covered	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$300 copay per visit, deductible does not apply.	$300 copay per visit, deductible does not apply.	$300 copay per visit, deductible does not apply.	None
	Emergency medical transportation	$300 copay per visit, deductible does not apply.	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay per visit, deductible does not apply.	$50 copay per visit, deductible does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission, deductible does not apply.	20% coinsurance	Not Covered	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit, deductible does not apply.	$15 copay per visit, deductible does not apply.	Not Covered	Network Partial hospitalization/intensive outpatient treatment: Tier 1 and Tier 2: $250 copay per visit, deductible does not apply.
	Inpatient services	$500 copay per admission, deductible does not apply.	20% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	$500 copay per admission, deductible does not apply.	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	$15 copay per visit, deductible does not apply.	$30 copay per visit.	Not Covered	Limits per calendar year: Physical, Speech, Occupational: 60 visits each; Cardiac: 36 visits Pulmonary: 20 visits
	Habilitative services	$15 copay per visit, deductible does not apply.	$30 copay per visit, deductible does not apply.	Not Covered	Services are provided under and limits are combined with Rehabilitation Services above.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider (You may pay more)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$500 copay per visit, deductible does not apply.	20% coinsurance	Not Covered	Limited to 60 days per calendar year (combined with inpatient rehabilitation).
	Durable medical equipment	10% coinsurance	20% coinsurance	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice services	10% coinsurance	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$30 copay per visit, deductible does not apply.	20% coinsurance	Not Covered	Limited to 1 exam every 24 months.
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private duty nursing
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 20 visits per calendar year
- Chiropractic (Manipulative care) – 20 visits per calendar year
- Hearing aids - $1,000 per 36 months
- Infertility Treatment
- Bariatric Surgery
- Routine eye care (adult) - 1 exam per 24 months

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-842-5520.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-842-5520.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-842-5520.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-842-5520 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-842-5520.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-842-5520.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-842-5520.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-842-5520.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$250**
Specialist copay	**$30**
Hospital (facility) copay	**$500**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$11,690**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,010**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$250**
Specialist copay	**$30**
Hospital (facility) copay	**$500**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$4,420**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$900
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$250**
Specialist copay	**$30**
Hospital (facility) copay	**$500**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,640**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$900
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.