UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare
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G&A PARTNERS
10813 S RIVER FRONT PKWY 140
C/O GA PARTNERS
SOUTH JORDAN, UT 840950000

Dear Customer:

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

You are receiving this package due to one of the following plan coverage events that requires you to receive an SBC.

- Upon application for coverage,
- Prior to any material modification of your plan coverage,
- Prior to your plan renewal, or
- You are a special enrollee.

If you are an Employer, you can find your group's SBC documents by logging into www.employereservices.com and select "Summary of Benefits and Coverage" under the Resources menu.

For more information regarding this document, please visit uhc.com/summary or contact the Member Services number on the back of your ID card.

Very truly yours,

Christopher Hock
Broker & Employer Operations
UnitedHealthcare

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$5,000** Indiv **/ $10,000** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$6,250** Indiv **/ $12,500** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-855-828-7715.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. An electronic approval is required to see a **Network** Specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-855-828-7715** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with referral	Your Cost If You Use a Network provider without referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	Not Covered	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Network Provider. Primary Physician must be assigned. Includes network OB/GYNs - no referral required.
	Specialist visit	$60 copay per visit	Not Covered	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Referrals must be from assigned Physician.
	Other practitioner office visit	$60 copay per visit	Not Covered	Not Covered	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period.
	Preventive care / screening/im-munization	No Charge	Not Covered	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins, after ded	30% co-ins, after ded	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay per service	$300 copay per service	Not Covered	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with Referral	Your Cost If You Use a Network Provider without Referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $25 copay	Retail: $10 copay Mail-Order: $25 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $35 copay Mail-Order: $87.50 copay	Retail: $35 copay Mail-Order: $87.50 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail: $60 copay Mail-Order: $150 copay	Retail: $60 copay Mail-Order: $150 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins, after ded	Not Covered	Not Covered	$150 outpatient surgery per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	30% co-ins, after ded	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room services	$300 copay per visit	$300 copay per visit	$300 copay per visit	None
	Emergency medical transportation	30% co-ins, after ded	30% co-ins, after ded	30% co-ins, after ded	Network Deductible applies.
	Urgent care	$100 copay per visit	$100 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins, after ded	Not Covered	Not Covered	$300 Inpatient Stay per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with referral	Your Cost If You Use a Network Provider without referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	30% co-ins, after ded	Not Covered	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay per visit	$60 copay per visit	Not Covered	Partial hospitalization/intensive outpatient therapy: 30% co-ins, after ded
	Mental/Behavioral health inpatient services	30% co-ins, after ded	30% co-ins, after ded	Not Covered	None
	Substance use disorder outpatient services	$60 copay per visit	$60 copay per visit	Not Covered	Partial hospitalization/intensive outpatient therapy: 30% co-ins, after ded
	Substance use disorder inpatient services	30% co-ins, after ded	30% co-ins, after ded	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	30% co-ins, after ded	Not Covered	Not Covered	$300 Inpatient Stay per occurrence deductible applies prior to the Annual Deductible.
If you need help recovering or have other special health needs	Home health care	30% co-ins, after ded	30% co-ins, after ded	Not Covered	Limited to 60 visits per policy period.
	Rehabilitation services	$30 copay per outpatient visit	$30 copay per outpatient visit	Not Covered	Limits per policy period: Physical, Speech, Occupational, Pulmonary 20 visits each. Cardiac 36 visits.
	Habilitative services	$30 copay per outpatient visit	$30 copay per outpatient visit	Not Covered	Services provided under and limits are combined with Rehabilitation services above.
	Skilled nursing care	30% co-ins, after ded	30% co-ins, after ded	Not Covered	Limited to 60 days per policy period (combined with Inpatient Rehabilitation).
	Durable medical equipment	30% co-ins, after ded	30% co-ins, after ded	Not Covered	Covers 1 per type of DME (including repair/replace) every 3 years.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with referral	Your Cost If You Use a Network Provider without referral	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Hospice service	30% co-ins, after ded	30% co-ins, after ded	Not Covered	None
If your child needs dental or eye care	Eye exam	$30 copay per visit	$30 copay per visit	Not Covered	Limited to 1 exam every 2 years.
	Glasses	Not Covered	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

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

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

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

- Hearing aids
- Routine eye care (Adult)
- Spinal Manipulations

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us at 1-855-828-7715 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Division of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,720
- **Patient pays** $5,820

Sample care costs:

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

Patient pays:

Deductibles	$5,300
Copays	$20
Coinsurance	$300
Limits or exclusions	$200
Total	**$5,820**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,760
- **Patient pays** $1,640

Sample care costs:

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

Patient pays:

Deductibles	$300
Copays	$1,300
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,640**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call **1-855-828-7715** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

Appendix A

Colorado Supplement to the Summary of Benefits and Coverage Form

UnitedHealthcare Insurance Company
Name of Carrier

Navigate VYG /2V
Name of Plan

Large Employer Group Policy
Policy Type

TYPE OF COVERAGE

1. Type of Plan	Preferred provider organization (PPO)
2. Out-of-network care covered? [1]	Only for emergency care
3. Areas of Colorado where plan is available	Plan is available only in the following areas: Adams, Alamosa Arapahoe, Archuleta, Bent, Boulder, Broomfield, Chafee, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, Eagle, El Paso, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Huerfano, Jefferson, Kiowa, Kit Carson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Miguel, Sedgwick, Summit, Teller, Washington, Weld & Yuma.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description	**What this means**
4. Deductible Period	Calendar year	Calendar year deductibles restart each January 1.
5. Annual Deductible Type	Individual/Family	"Individual" means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover those expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family").

6. What cancer screenings are covered?	Breast Cancer Screening - Cervical Cancer Screening - Colorectal Cancer Screening -Prostate Cancer Screening.

LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered persons age 19 and older. [2]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
8. How does the policy define a "pre-existing condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
9. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No

USING THE PLAN

10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
11. Does the plan have a binding arbitration clause?	No

Questions: Call **1-800-516-3344** or visit us at **www.UnitedHealthcare.com**.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Emal: insurance@dora.state.co.us

Language Access Services:

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

Endnotes

1 "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask you carrier or plan sponsor (e.g., employer) for details.

UNITEDHEALTHCARE HAS PREPARED AND MAINTAINS A NETWORK ACCESS THAT DESCRIBES HOW THE PLAN MONITORS THE NETWORK OF PROVIDERS TO ENSURE THAT YOU HAVE ACCESS TO NETWORK PROVIDERS. THE ACCESS ALSO HAS INFORMATION ON THE REFERRAL PROCESSES, COMPLAINT PROCEDURES, QUALITY PROGRAMS AND EMERGENCY SERVICES COVERAGE PROVISIONS. THE NETWORK ACCESS PLAN IS AVAILABLE AT THE PLAN'S OFFICE: 6465 GREENWOOD PLAZA BLVD, SUITE 300, CENTENNIAL, CO, 80111 OR CALL (800) 842-4509.