

Attachment A
Solicitation Number: 122436 O5
INTENT TO PROPOSE

Date:	6/12/2025
To:	Monica Casarez, Segal (mcasarez@segalco.com)
From:	United HealthCare Services, Inc.
	Name and Title: Jelena Edwards, Strategic Account Executive
Re:	State of Nebraska – Administrative Support Services for the State of Nebraska Employee Health Care Prescription Drug Benefit Plans – RFP # 122436 O5

Non-Disclosure Agreement	
Authorized signer Name and Title:	Robert Broomfield, Health Plan CEO
Email:	rob_broomfield@uhc.com
Phone:	860-702-5000
Company Name:	United HealthCare Services, Inc.
Company Address:	9700 Health Care Lane
	Minnetonka, Minnesota 55343
Designated contact to receive secure data for this RFP	
Name and Title:	Jelena Edwards, Strategic Account Executive
Email:	jelena_edwards@uhc.com
Phone	224-231-1221

In order that the State of Nebraska may assess potential vendor interest, please indicate Yes or No below and return to mcasarez@segalco.com. Thank you.

Our company intends to propose:	Yes/No	If No, reason for declining:
Administrative Support Services for the State of Nebraska Employee Health Care Prescription Drug Benefit Plans – RFP # 122436 O5	Yes	

Declining to respond will not eliminate the vendor from future consideration for jobs with the State of Nebraska.

STATE OF NEBRASKA

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") amends and is made a part of all Services Agreements (as defined below) between United Healthcare Services, Inc. ("Business Associate") and State of Nebraska ("Company") on behalf of the Group Health Plans sponsored by Company (the "Plan"). This Agreement is effective July 1, 2026 or upon the effective date of the underlying Services Agreement, whichever is later ("Effective Date"). This Agreement supersedes and replaces any prior Business Associate Agreements between the parties.

1. **Definitions.**

a. **Catch-all definitions.** The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Covered Entity, Data Aggregation, Designated Record Set, Disclose or Disclosure, Electronic Protected Health Information, Health Care Operations, Minimum Necessary, Notice of Privacy Practices, Protected Health Information or PHI, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use. Other capitalized terms used but not otherwise defined in this Agreement shall have the meaning ascribed in the HIPAA Rules.

b. **Specific definitions.**

(1) **"Business Associate"** shall generally have the same meaning as the term "Business Associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean the party identified above as Business Associate.

(2) **"Business Associate Functions"** means functions performed by Business Associate on behalf of the Plan in the course of providing or arranging for plan administration services which involve the creation, receipt, maintenance or transmission of PHI by Business Associate or its agents or Subcontractors. It is anticipated that the services provided by Business Associate will be performed as part of the Plan's "health care operations" as defined in the HIPAA Rules.

(3) **"HIPAA Rules"** shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended at the time the section is to be applied.

(4) **"Individual"** shall generally have the same meaning ascribed in the HIPAA Rules and shall refer only to Individuals who are covered persons under the Plan.

(5) **"Services Agreements"** means all agreements whether now in effect or hereafter entered into, between Company and Business Associate for the performance of Business Associate Functions by Business Associate on behalf of the Plan.

2. **Purpose.** The Plan is a Covered Entity under HIPAA. The HIPAA Rules require the Plan to obtain, and Business Associate to provide, satisfactory written contractual assurances before Business Associate may create, receive, maintain, or Disclose PHI to perform Business Associate Functions on behalf of the Plan. This Agreement is entered into to provide the contractual assurances required under the HIPAA Rules.

3. **Obligations of Business Associate.** As an express condition of performing Business Associate Functions, Business Associate agrees to:

a. Not Use or Disclose PHI other than as permitted or required by this Agreement or as otherwise Required by Law.

b. Use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information, to prevent Use or Disclosure of PHI other than as provided for in this Agreement.

c. Report to the Plan's designated privacy official, without unreasonable delay but in no event more than three (3) business days after discovery by Business Associate, any Use or Disclosure of PHI not provided for by this Agreement of which Business Associate becomes aware, including any Breach of Unsecured Protected Health Information as required at 45 CFR 164.410, and any Security Incident of which it becomes aware, together with any remedial or mitigating action taken or proposed to be taken with respect thereto. If Business Associate does not have available complete information in satisfaction of 45 CFR 164.410(c) within three (3) business days of discovery of the impermissible Use or Disclosure, Business Associate shall provide all information it has at such time and immediately update the Plan with additional information as it becomes available through prompt investigation. This Agreement serves as Business Associate's notice to the Plan that attempted but unsuccessful Security Incidents regularly occur and that no further notice will be made by Business Associate unless there has been a successful Security Incident or attempts or patterns of attempts that Business Associate determines to be suspicious.

Business Associate shall cooperate with the Plan in mitigating any harmful effects of any impermissible Use or Disclosure. In the case of a Breach as determined to exist in the sole discretion of the Plan which was due to a violation of this Agreement by Business Associate, Business Associate shall pay for the reasonable costs of investigation, mitigation and notification to affected Individuals. As an alternative to Business Associate reimbursing Company and the Plan for the costs of notification, the Plan may elect to have Business Associate directly provide the notifications to Individuals for breaches caused by Business Associate, provided that Company and the Plan shall have final approval of all content of notifications to Individuals.

d. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information.

e. Within ten (10) business days of request by an Individual or notification by the Plan, make available to the Individual such Individual's PHI maintained by Business Associate in a Designated Record Set in accordance with 45 CFR 164.524. The

parties agree that Individuals will be directed to Business Associate to make all requests for access to PHI. Business Associate will provide such access according to its own procedures for such access in accordance with the requirements of 45 CFR 164.524. If the requested PHI is maintained in one or more Designated Record Sets electronically and if the Individual requests an electronic copy of such PHI, Business Associate must provide the Individual with access to PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to between Business Associate and the Individual. Business Associate shall provide the requested information directly to the Individual, along with a notice to the Individual that a copy of the individual's request has been furnished to the Plan and that the Plan may provide additional information to the Individual in response to the request.

If the Individual's request covers records not maintained by Business Associate, Business Associate shall notify the Plan within three (3) days of the request. The Plan will be responsible for providing access or otherwise responding directly to the Individual pursuant to the HIPAA Rules with respect to PHI not in the possession of Business Associate or an agent or subcontractor of Business Associate. Business Associate may charge the Individual reasonable fees related to this access, as determined by Business Associate, but only in such amounts as permitted by the HIPAA Rules. The Plan authorizes Business Associate to require payment of such fees from the Individual prior to releasing any records.

f. Business Associate agrees to receive requests for amendment and amend PHI as required by 45 CFR 164.526 on the Plan's behalf for as long as such information is maintained by Business Associate. The parties agree that Individuals will be directed to Business Associate to make all such requests for amendment of PHI. Business Associate will amend such PHI according to its own procedures for such amendment in accordance with the requirements of 45 CFR 164.526. If the Individual's request covers records not maintained by Business Associate, Business Associate shall notify the Plan within three (3) days of such request. The Plan will be responsible for amending or otherwise responding directly to the Individual pursuant to the HIPAA Rules with respect to PHI not in the possession of Business Associate or an agent or contractor of Business Associate. Business Associate shall notify the Plan of any amendments made to PHI.

g. Business Associate agrees to process all requests for disclosure accounting by Individuals for as long as such information is maintained by Business Associate. Individuals will be directed to Business Associate to make all such requests. Business Associate will provide the accounting that is required under 45 CFR 164.528 on the Plan's behalf directly to the Individual. Business Associate will provide such accounting according to its own procedures for such accounting in accordance with the requirements of 45 CFR 164.528.

Business Associate shall notify the Plan within three (3) days of any request made by an Individual for a disclosure accounting. The Plan will be responsible for responding directly to the Individual (or the Individual's personal representative) pursuant to 45 CFR 164.528 with respect to disclosures of PHI by persons or entities other than Business Associate or a subcontractor or agent of Business Associate.

Business Associate shall provide directly to the Individual the requested accounting of disclosures made by Business Associate or a subcontractor or agent of Business Associate, along with a notice to the Individual that a copy of the Individual's request has been furnished to the Plan and that the Plan may provide additional information to the Individual in response to the request.

h. Make its internal practices, books and records relating to this Agreement available to the Secretary of HHS and to the Plan for purposes of determining the Plan's and Business Associate's compliance with the HIPAA Rules.

i. So that the Plan may meet its obligations to evaluate requests for restrictions and confidential communications in connection with the disclosure of PHI under 45 CFR 164.522, Business Associate and the Plan agree that, to the extent that communications are within the control of Business Associate, Business Associate will perform these evaluations on behalf of the Plan. Business Associate will evaluate such requests according to its own procedures for such requests, in accordance with the requirements of 45 CFR 164.522, and shall implement such appropriate operational steps as are required by its own procedures. Such evaluation will not relieve the Plan of any additional and independent obligations to evaluate restrictions or implement confidential communications where requested by an Individual. Accordingly, Business Associate will evaluate requests for restrictions and requests for confidential communications and will respond to these requests as appropriate under Business Associate's procedures. The Plan agrees that it will not agree to such restriction or request that would affect Business Associate without the approval of Business Associate, so that Business Associate can determine whether it can reasonably administer the request.

j. So that the Plan may meet its obligation to evaluate complaints from Individuals regarding their privacy rights or privacy practices of the Plan or Business Associate, the parties agree that Individuals shall be directed to submit any such complaint to Business Associate for review and evaluation. Business Associate will evaluate such complaints according to its own procedures for complaints and shall implement appropriate operation steps as are required by its own procedures. The Privacy Officer of the Plan shall cooperate with Business Associate in the evaluation of any such complaint. Business Associate shall provide a copy of all complaints to the Plan within three (3) days of receipt by Business Associate. If the complaint appears to involve handling of PHI by the Plan, Plan Sponsor, or other Business Associate of the Plan, Business Associate shall notify the Plan, and it shall be the Plan's responsibility to review and evaluate the complaint.

k. Limit the Uses and Disclosures of, or requests for, PHI for purposes described in this Agreement to the Minimum Necessary to perform the required Business Associate Functions. Business Associate shall comply with any additional requirements for the determination of Minimum Necessary as are required from time to time by the HIPAA Rules, as amended, or through additional guidance published by the Secretary.

l. To the extent Business Associate is expressly obligated under the Services Agreements to carry out one or more of the Plan's obligations(s) under Subpart E of

45 CFR Part 164, comply with the requirements of Subpart E that apply to the Plan in the performance of such obligation(s).

m. Except for the specific Uses and Disclosures for the Business Associate's own management and administration or to carry out the legal responsibilities of Business Associate, Business Associate shall not Use or Disclose PHI in a manner that would violate the HIPAA Rules if done by the Plan.

4. **Permitted Uses and Disclosures of PHI.** Business Associate shall only Use or Disclose PHI as follows:

a. Business Associate may Use or Disclose PHI as Required by Law. Business Associate agrees to follow the current law covering the use and disclosure of PHI related to substance abuse and reproductive health.

b. Business Associate may Use or Disclose PHI as necessary to carry out Business Associate Functions.

c. Business Associate may Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

d. Business Associate may Disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided the Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that the information will remain confidential and be Used or further Disclosed only as Required by Law or for the purposes for which it was Disclosed to the person, and the person notifies Business Associate in writing of any instances of which it is aware in which the confidentiality of the information has been breached or compromised.

e. If specifically identified as a Business Associate Function in the Services Agreements, Business Associate may provide Data Aggregation services relating to the Health Care Operations of Covered Entity.

f. If de-identification is listed as a Business Associate Function in the Services Agreements, or if Business Associate is expressly permitted to de-identify PHI and use data thus de-identified for its own uses in the Services Agreements, Business Associate may Use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c). Business Associate may use de-identified data only for the purposes specified in the Services Agreements.

5. **Responsibilities of the Plan.** The Plan agrees to:

a. Notify Business Associate promptly of any restriction on the Use or Disclosure of PHI that the Plan has agreed to or is required to abide by under 45 CFR 164.522, to the extent such restriction may affect Business Associate's Use or Disclosure of PHI.

b. Notify Business Associate of any changes in, or revocation of, the permission by an Individual to Use or Disclose PHI, to the extent that such changes may affect Business Associate's Use or Disclosure of PHI.

c. Provide Business Associate with a copy of any amendment to PHI which is accepted by Covered Entity under 45 CFR 164.526 which Covered Entity believes will apply to PHI maintained by Business Associate in a Designated Record Set.

d. Not request Business Associate to Use or Disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by the Plan, with exception for any Data Aggregation services permitted under Section 4.

6. **Compliance with Electronic Transactions Rule.** If Business Associate conducts in whole or part electronic Transactions (as defined in 45 CFR 160.103) on behalf of Covered Entity for which the Secretary of HHS has established standards, Business Associate will comply, and will require any Subcontractor involved with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule at 45 CFR Parts 160 and 162 and of any operating rules adopted by the Secretary of HHS with respect to Transactions.

7. **Supervening Law.** Upon the enactment of any law or regulation affecting the Use or Disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, the parties agree to amend this Agreement in such manner as is necessary to comply with such law or regulation. If the parties are unable to agree on an amendment within thirty (30) days, either party may terminate the Services Agreements on not less than thirty (30) days' written notice to the other.

8. **Liability and Indemnification.** Each party shall be responsible for the acts and omissions of its own agents, employees and contractors. Notwithstanding the foregoing, and notwithstanding any limitation of liability or disclaimer of damages in the Services Agreements or elsewhere, to the extent that the Secretary determines that Business Associate is acting as an agent of the Plan under the Services Agreements or this Agreement, Business Associate shall indemnify Company and the Plan for any fines, civil monetary penalties or monetary resolutions incurred by Company or the Plan, plus reasonable attorneys' fees of Company and the Plan, arising out of or relating to the actions or omissions of Business Associate which constitute a breach of this Agreement by Business Associate. This indemnification is in addition to any additional indemnification provided by Business Associate in the Services Agreement.

9. **Term and Termination.**

a. **Term.** This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the parties have been met, including return or destruction of all PHI in Business Associate's possession (or in the possession of Business Associate's agents and Subcontractors), unless sooner terminated as provided herein. It is expressly agreed that the terms and conditions of this Agreement designed to safeguard PHI shall survive expiration or other termination of the Services Agreements and shall continue in effect until Business Associate has

performed all obligations under this Agreement and has either returned or destroyed all PHI.

b. **Termination.** Company may immediately terminate this Agreement and the Services Agreements, if Company and/or the Plan makes the determination that Business Associate has breached a material term of this Agreement. Alternatively, Company may choose to provide Business Associate with written notice of the existence of an alleged material breach, and afford Business Associate an opportunity to cure the alleged material breach upon mutually agreeable terms. Failure to take reasonable steps to cure the breach is grounds for the immediate termination of this Agreement.

c. **Business Associate Obligations Upon Termination.** Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from the Plan, or created, maintained, or received by Business Associate on behalf of the Plan, shall:

- (i) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities or as to which Business Associate reasonably determines such PHI is technically incapable of being returned or destroyed;
- (ii) Return to the Plan or, if not provided for in the Services Agreements, destroy the PHI retained under 8.c.(i) that the Business Associate maintains in any form;
- (iii) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information retained by Business Associate to prevent Use or Disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
- (iv) Not Use or Disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Sections 4.c. and 4.d. which applied prior to termination; and
- (v) Return to the Plan or, if not provided for in the Services Agreements, destroy the PHI retained by Business Associate under Section 8.c.(i) when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities, except where Business Associate reasonably determines such PHI is not technically capable of being returned or destroyed.

10. **Miscellaneous.**

a. **Applicability.** For purposes of this Agreement, and as applicable to the Business Associate Functions of Business Associate under the Services Agreements covered by this Agreement, references to the Plan shall include the named Plan and all

other group health plans subject to HIPAA and sponsored by Company that participate in an organized health care arrangement.

b. **Survival.** The respective rights and obligations of Business Associate and the Plan or Company hereunder shall survive termination of this Agreement according to the terms hereof and the obligations imposed on the Plan or Company and Business Associate under the HIPAA Rules.

c. **Interpretation; Amendment.** This Agreement shall be interpreted and applied in a manner consistent with the Plan's and Business Associate's obligations under the HIPAA Rules. All amendments shall be in writing and signed by both parties, except that this Agreement shall attach to additional Services Agreements entered into between the parties in the future without the necessity of amending this Agreement each time. This Agreement is intended to cover the entire Business Associate *relationship* between the parties, as amended, from time to time, through Services Agreements or other means.

d. **Waiver.** A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies or obligations.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

Company:

Business Associate:

State of Nebraska

Signature: _____

Signature: Jennifer Dumas
Jennifer Dumas (07/17/2025 12:20 EDT)

Printed Name: _____

Printed Name: Jennifer Dumas

Title: _____

Title: Contract Negotiator

Date Signed: _____

Date Signed: 07/17/2025

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COST SHEET
SOLICITATION NUMBER 122436 O5

Pharmacy Benefit Management Services Fees

Bidder: United HealthCare Services, Inc.

Financial Proposal Work Sheet: Enter the per Member per Month (PMPM) fees for Section I - Standard Services below for the plan designs currently in place. United Response: United's base pharmacy administration fee is Per EMPLOYEE Per Month (PEPM). Due to billing system restraints we are unable to provide on a PMPM basis.

Fees on any other basis, (i.e., as a percentage of claims, on a per claim basis or a combination) will NOT be considered. The ASO Fees are to be guaranteed for the three (3) year contract period. Any ancillary service relating to the administration of the health plan not specifically identified in bidder's proposal is assumed to be included in the ASO fee. All services covered under the fee should be listed. **IF THE FEE STRUCTURE IS DIFFERENT BY PLAN, COMPLETE THIS SCHEDULE FOR EACH PLAN AND LABEL EACH SCHEDULE ACCORDINGLY.** Enrollment figures represent estimated counts.

Section I - Pharmacy Benefit Management Services Fees	Initial Contract Term			1st Option Year	2nd Option Year
	Year 1	Year 2	Year 3	Year 4	Year 5
	Estimated Number of Enrolled Employees	Estimated Number of Enrolled Employees	Estimated Number of Enrolled Employees	Estimated Number of Enrolled Employees	Estimated Number of Enrolled Employees
Number of Enrolled Members Employees=>	13,809	13,809	13,809	13,809	13,809
PBM Fees per Member per Month (PMPM) - <u>NOTE: United's admin fee is Per EMPLOYEE Per Month (PEPM). Due to billing system restraints we are unable to provide on a PMPM basis.</u>					
	\$2.50	\$2.60	\$2.70	\$2.80	\$2.90
Pharmacy Benefit Management and Administration Fee					
Toll Free Phone Lines					
Monthly Data Feeds to Fund or Designee(s) - <u>Not included, additional cost applies</u>					
Prospective /Concurrent/Retro DUR					
Standard Reports					
Ad Hoc Reports - <u>Not included, additional cost applies</u>					
COB Program					
First Level Appeals					
Second Level Appeals					
Urgent Appeals					
Formulary and Rebate Administration					
Prior Authorization Program					
Fraud and Abuse Program					
Step Therapy Program					
Quantity Limitations					
Dose Optimization					
Medication Management					
Custom System Overrides - <u>Not included , additional cost applies</u>					
Manual Claim Processing - <u>Not included, additional cost may apply</u>					
Annual EOB Statements					
Retro Termination Letters					
Member-submit Claims					
Drug Notification Letters					
Member Formulary Guides					
Member ID Cards					
Member Mailing Postage					
Enrollment Packet Mailing					
Audit Recovery Fees					
E-Prescribing					
Vaccine Services					
Section I - Standard Services MONTHLY TOTAL	\$34,522.50	\$35,903.40	\$37,284.30	\$38,665.20	\$40,046.10

Section II - Credits/Allowances		Initial Contract Term			1st Option Year	2nd Option Year
		Year 1	Year 2	Year 3	Year 4	Year 5
		Self-Funded Population	Self-Funded Population	Self-Funded Population	Self-Funded Population	Self-Funded Population
Indicate your willingness to offer the listed credits/allowances ("Y/N"). If "Y", then indicate the annual dollar amount of the credit/allowance for each plan year.						
Description	Y/N	13,809	13,809	13,809	13,809	13,809
One-time Implementation Credit	N	N/A	N/A	N/A	N/A	N/A
General Pharmacy Program Management - including communication expenses, clinical programs, consulting fees or be used as a credit against claim invoices.	Yes - once per enrolled member	\$5.00	\$5.00	\$5.00	\$5.00	\$5.00
Other . . .	N	N/A	N/A	N/A	N/A	N/A
Section II - Credits/Allowances ANNUAL TOTAL		\$5.00	\$5.00	\$5.00	\$5.00	\$5.00

Section III - Additional and/or Optional Programs/Services		Initial Contract Term			1st Option Year	2nd Option Year
		Year 1	Year 2	Year 3	Year 4	Year 5
		Self-Funded Population	Self-Funded Population	Self-Funded Population	Self-Funded Population	Self-Funded Population
List and describe any additional and/or optional services proposed, the associated administration charges, and the average expected monthly total for each service. Add lines, as needed to accommodate all fees.						
<u>Note: This section will not count toward Evaluation Scoring.</u>						
Service Description	Service Fee and Structure (PSPM, PMPM, X% of Savings, etc.)	Estimated Monthly Total	Estimated Monthly Total	Estimated Monthly Total	Estimated Monthly Total	Estimated Monthly Total
Monthly Data Feeds to Fund or Designee(s)	Cost varies by request; Per file					
Ad hoc Reporting or Data/Eligibility Feeds	Cost varies by request; Per report or file					
Variable Copay Program	\$.45 Per Eligible Member Per Month					
Customization of any service	Cost varies by request; Per Request					
Section III - Additional/Optional Services MONTHLY TOTAL		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

COST SHEET
SOLICITATION NUMBER 122436 O5
PBM Pricing Guarantees

Bidder: United HealthCare Services, Inc.

Prescription Drug Pricing and Rebates:

AWP Reimbursement Basis—Complete the following table using the drug reimbursement that your organization is willing to guarantee, on a dollar-for-dollar basis, for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback, including usual & customary and zero-balance claims prior to the impact of member cost sharing. Generic discount guarantee must include all single-source as well as multi-source generic drugs.

The aggregate brand discount guarantee for specialty drugs should include biosimilar specialty drugs. In addition to the aggregate specialty drug discount and rebate guarantees, please provide separately a list of all specialty drugs and their individual discount guarantees.

Specialty drug pricing must be based on an open (non-exclusive) basis. **United Response: Not confirmed. Our quote requires exclusive specialty. Carve out or slicing of specialty or any other pharmacy service/component is not permitted.**

		Self-Funded Population		
		Pharmacy Network		
Guaranteed Pricing for Non-Specialty Medications				
Channel		Retail	Retail	Mail
Day Supply (DS)		</=30 DS	31 - 90 DS	>0 DS
AWP Discount for All Brands				
	Year 1	19.5%	20.0%	20.0%
	Year 2	19.5%	20.0%	20.0%
	Year 3	19.5%	20.0%	20.0%
	Year 4	19.5%	20.0%	20.0%
	Year 5	19.5%	20.0%	20.0%
AWP Discount for All Generics Including Single-Source				
	Year 1	88.0%	88.0%	91.5%
	Year 2	88.0%	88.0%	91.5%
	Year 3	88.0%	88.0%	91.5%
	Year 4	88.0%	88.0%	91.5%
	Year 5	88.0%	88.0%	91.5%
Dispensing Fee/Rx				
	Year 1	\$0.34	\$0.00	\$0.00
	Year 2	\$0.34	\$0.00	\$0.00
	Year 3	\$0.34	\$0.00	\$0.00
	Year 4	\$0.34	\$0.00	\$0.00
	Year 5	\$0.34	\$0.00	\$0.00
		Specialty Pharmacy		
Guarantee Pricing for Specialty Medications				
Channel		Retail	Retail	Mail
Day Supply (DS)		</=30 DS	31 - 90 DS	>0 DS
AWP Discount for All Brands				
	Year 1	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%
	Year 2	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%
	Year 3	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%
	Year 4	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%
	Year 5	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%	LDD 14%; Non-LDD 19%; Unlisted 14%
AWP Discount for All Generics				
	Year 1	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%
	Year 2	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%
	Year 3	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%
	Year 4	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%
	Year 5	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%	Generic 80%; Unlisted 14%
Dispensing Fee/Rx				
	Year 1	\$0.00	\$0.00	\$0.00
	Year 2	\$0.00	\$0.00	\$0.00
	Year 3	\$0.00	\$0.00	\$0.00
	Year 4	\$0.00	\$0.00	\$0.00
	Year 5	\$0.00	\$0.00	\$0.00
Rebates & Other Manufacturer Revenue				
	%-Share	100%		
Guaranteed Minimum Per Brand Claim Rebate Guarantees <i>United Response: Shared 100% rebate minimum guarantess are on a Per Member Per Month (PMPM) basis.</i>				
Non-Specialty Medications				
	Year 1	\$133 PMPM	\$133 PMPM	\$133 PMPM
	Year 2	\$157 PMPM	\$157 PMPM	\$157 PMPM
	Year 3	\$184 PMPM	\$184 PMPM	\$184 PMPM
	Year 4	\$184 PMPM	\$184 PMPM	\$184 PMPM
	Year 5	\$184 PMPM	\$184 PMPM	\$184 PMPM
Specialty Medications				
	Year 1	\$133 PMPM	\$133 PMPM	\$133 PMPM
	Year 2	\$157 PMPM	\$157 PMPM	\$157 PMPM
	Year 3	\$184 PMPM	\$184 PMPM	\$184 PMPM
	Year 4	\$184 PMPM	\$184 PMPM	\$184 PMPM
	Year 5	\$184 PMPM	\$184 PMPM	\$184 PMPM

UNITEDHEALTHCARE PHARMACY; STATE OF NEBRASKA PHARMACY BENEFITS PARTNERSHIP

Thank you for the opportunity to reaffirm why UnitedHealthcare and UnitedHealthcare Pharmacy are the right partners to continue delivering integrated pharmacy benefits to the public servants and families of the State of Nebraska. This pharmacy proposal is expressly contingent upon the award of the medical business. Our partnership, built over more than a decade, has consistently delivered high service ratings, cost-effective solutions, and improved health outcomes.

We understand your goal: to provide a better experience for your members—delivering the right care, at the right place, and at the right price. In today's complex pharmacy landscape—shaped by rising specialty drug costs, ultra-high-cost gene therapies, the growing demand for GLP-1s, and an evolving regulatory environment—having a trusted PBM partner is more critical than ever.

At UnitedHealthcare Pharmacy, we are committed to delivering affordable, evidence-based drug benefits that put your teammates at the center of care. Our integrated approach simplifies the experience for both teammates and care providers—leveraging innovation, technology, and data to maximize value from day one.

Here's how we help you deliver expert, cost-effective care:

THE RIGHT CONNECTIONS

We integrate medical and pharmacy benefits to manage total cost of care—not just medication costs. This visibility allows us to make real-time decisions, place drugs on the right formulary, and adjust coverage as needed.

THE RIGHT COST

- For the State: We reduce total cost of care through cross-benefit drug management, evidence-based exclusions, and member affordability strategies.
- For your Teammates: We offer digital tools and coverage insights that help teammates understand their pharmacy costs and find lower-cost alternatives.

THE RIGHT EXPERIENCE

- For the State: Continued partnership with a seasoned account management team that has supported you for over a decade—bringing consistency, deep understanding, and trusted collaboration.
- For your Teammates: We support teammates with personalized advocacy, streamlined digital tools, and clinical guidance. This leads to higher engagement, better decision-making, and lower out-of-pocket costs, which are ultimately driving productivity and satisfaction.

COMMITMENT TO THE STATE OF NEBRASKA

Since 2012, we've supported the State of Nebraska with tailored benefit programs. Our current proposal reflects:

- A pharmacy contract and experience that is integrated with medical, ensuring simplicity and alignment



- A clear understanding of the State's goals for cost-effective, high-quality benefits for active employees, retirees, COBRA participants, and dependents
- A commitment to transparency, innovation, and community engagement

We appreciate your continued trust and look forward to building on our shared success. UnitedHealthcare Pharmacy is ready to help the State of Nebraska navigate the future of pharmacy care with confidence, clarity, and compassion.



Prepared: 7/14/2025

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees) and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, (hereinafter referred to as "Fees") payable by Customer under this Agreement will be adjusted through a credit to Customer's Service Fees in accordance with the arrangements set forth below unless otherwise noted.

Unless otherwise specified, these arrangements apply to pharmacy benefits and are effective for the period beginning 07/01/2026 and ending on 06/30/2029 (each twelve month period is a "Guarantee Period"). With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

The arrangements will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date the Agreement is signed by both parties. In the event these arrangements become effective later than the effective date of the Guarantee Period the arrangements will commence with the Agreement Period during which the 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 United's failure is due to Customer's actions or inactions or if United fails to meet these standards due to fire, embargo, strike, war, accident, pandemic, 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 provided that this Agreement remains in force, United may specify to Customer in writing new arrangements for the subsequent Guarantee Period. If United specifies new arrangements, United will also provide Customer with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Pharmacy Financials				
Definition	Pharmacy rate guarantees.			
Measurement and Criteria		07/01/2026	07/01/2027	07/01/2028
	Component Discount Guarantee - Broad Network			
	Retail Brand, Average Wholesale Price (AWP) less	19.50%	19.50%	19.50%
	Retail Brand -- 90 Day Supply, AWP less	20.00%	20.00%	20.00%
	Retail Generic - 30 and 90 Day Supply, AWP less	88.00%	88.00%	88.00%
	Mail Order Brand, AWP less	20.00%	20.00%	20.00%
	Mail Order Generic, AWP less	91.50%	91.50%	91.50%
	The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component.			
	Dispensing Fees - Broad Network			
	Retail Brand - 30 Day	\$0.34	\$0.34	\$0.34
	Retail Brand -- 90 Day Supply	\$0.00	\$0.00	\$0.00
	Retail Generic - 30 Day	\$0.34	\$0.34	\$0.34
	Retail Generic -- 90 Day Supply	\$0.00	\$0.00	\$0.00
	Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.			
	Minimum Rebate Guarantee (Advantage PDL)			
	Rebate Sharing Percentage	100.0%	100.0%	100.0%
	Basis, per member per month	PMPM	PMPM	PMPM
	Guaranteed Minimum	\$133.00	\$157.00	\$184.00
	Credits and Allowances			
	Pharmacy Management Allowance (once per enrolled member)	\$5.00	\$5.00	\$5.00
	Fees			
	Pharmacy Administration Fee (PEPM)	\$2.50	\$2.60	\$2.70
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 guaranteed dispensing fee.			
Payment Amount -- Rebates	The amount the actual Rebate amount is less than the 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.			

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• 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

• All Specialty drugs are excluded from the Retail and Mail guarantees and are 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 90 day supply Retail guarantee includes drugs dispensed for 84 days or greater; claims with less than 84 days' supply are included with Retail 30.

• The Mail Order guarantee includes drugs dispensed for any days' supply

• 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

• PMPM guarantees may be adjusted in the event the ratio of enrolled Participants to Subscribers varies by more than 5% from assumptions or if 340B rejection rates materially deviate those assumed in developing the guarantees.

• Assumes implementation of United's Advantage PDL

• 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.

• 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.

• The Rebate guarantees assume Stelara is excluded from coverage; Rebate payment or reconciliation adjustments will not apply to utilization of therapeutically equivalent, low WAC Stelara biosimilars.

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
- If the average Specialty Brand days' supply declines below 31

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• 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.*

Credits and Allowances

• Pharmacy Management Allowance: United will provide a credit allowance to help Customer mitigate costs appropriately associated with the administration of the pharmacy program. This credit allowance is available once the parties have an executed Agreement and the first month of service fees under the Agreement has been received by United. Upon request from the Customer, a credit will be issued in United's fee billing system

Market Check

Customer may conduct one market check during the Pharmacy Pricing Term to confirm its financial terms are competitive with those currently available in the market for substantially similar customers. Such analysis shall:

- be initiated after the first anniversary of the Effective Date of the Agreement
- be conducted by a mutually agreed upon third party
- include no fewer than four substantially similar customers under active contracts as determined by the following criteria which must be included in the market check report:
 - Within 10% of total membership count
 - Same customer type (carve-in, coalition, etc.)
 - Same line of business (commercial, Medicare, Medicaid, etc.)
 - Same types of services (retail, home delivery, specialty, etc.)
 - Comparison of pricing for same contract year
 - Pricing quoted within past six-month period
 - A majority of membership located in a comparable geographic region
- The market check will compare the aggregate value of pricing terms including the combined net value of:
 - Ingredient cost discounts and dispensing fees from retail pharmacies, home delivery pharmacies, and specialty pharmacies
 - Rebates
 - Administrative fees
 - Client Credits

If the market check report validates an annualized savings of greater than three (3) percent between the median of the financial terms for such substantially similar customers and Customer's financial terms for time period that is the subject of the market check, the parties will negotiate in good faith to revise the financial terms. United responds to Customer within 30 days of receipt of the complete market check report containing sufficient information for United to validate that the analysis was conducted in accordance with the above criteria. Any revisions to financial terms resulting from the parties' negotiations are effective the first day of the following contract year, subject to the parties having agreed to revisions in writing at least 30 days prior to the effective date.

General Conditions

- All pricing guarantees shall remain in effect for the entire contract period of 07/01/2026 through 06/30/2029 ("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.
- In the event vaccines are covered under the pharmacy benefit, vaccines will be excluded from the discount, dispense fee and rebate guarantees.
- On mail order and 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.
- Pricing and guarantees assume enrollment of 13,809 Employees and 28,592 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's Price Edge program applies

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.

PTRX (12/2024)

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees) and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, (hereinafter referred to as "Fees") payable by Customer under this Agreement will be adjusted through a credit to Customer's Service Fees in accordance with the arrangements set forth below unless otherwise noted.

Unless otherwise specified, these arrangements apply to pharmacy benefits and are effective for the period beginning 07/01/2026 and ending on 06/30/2029 (each twelve month period is a "Guarantee Period"). With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

The arrangements will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date the Agreement is signed by both parties. In the event these arrangements become effective later than the effective date of the Guarantee Period the arrangements will commence with the Agreement Period during which the 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 United's failure is due to Customer's actions or inactions or if United fails to meet these standards due to fire, embargo, strike, war, accident, pandemic, 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 provided that this Agreement remains in force, United may specify to Customer in writing new arrangements for the subsequent Guarantee Period. If United specifies new arrangements, United will also provide Customer with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Specialty Pharmacy							
Specialty Pharmacy Discount Guarantee							
Definition	Specialty drug discount guarantees are based on actual specialty drug utilization for specialty drugs dispensed through all channels (Retail, Mail Order and 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			07/01/2026	07/01/2027	07/01/2028	
	LDD Brand			14.00%	14.00%	14.00%	
	Non-LDD Brand			19.00%	19.00%	19.00%	
	Generic			80.00%	80.00%	80.00%	
	Unlisted			07/01/2026	07/01/2027	07/01/2028	
	All Include LDD			14.00%	14.00%	14.00%	
Criteria	Actual utilization, using Average Wholesale Price (AWP) in dollars, using our data, of listed specialty drugs dispensed through all channels (Retail, Mail Order and United's 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 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	NEMLUVIO	Yes	Included
ANEMIA	ARANESP	No	Included	INFLAMMATORY CONDITIONS	OLUMIANT	No	Included
ANEMIA	EPOGEN	No	Included	INFLAMMATORY CONDITIONS	OMVOH	No	Included
ANEMIA	PROCRIT	No	Included	INFLAMMATORY CONDITIONS	OPZELURA	No	Included
ANEMIA	RETACRIT	No	Included	INFLAMMATORY CONDITIONS	ORENCIA	No	Included
ANTIBACTERIALS	ARIKAYCE	Yes	Included	INFLAMMATORY CONDITIONS	OTEZLA	No	Included
ANTICONSULTANTS	DIACOMIT	Yes	Included	INFLAMMATORY CONDITIONS	RIDAURA	No	Included
ANTICONSULTANTS	EPIDIOLEX	Yes	Included	INFLAMMATORY CONDITIONS	RINVOQ	No	Included
ANTICONSULTANTS	FINTEPLA	Yes	Included	INFLAMMATORY CONDITIONS	SILIQ	No	Included
ANTICONSULTANTS	ZTALMY	Yes	Included	INFLAMMATORY CONDITIONS	SIMLANDI	No	Included
ANTIHYPERLIPIDEMIC	JUXTAPID	Yes	Included	INFLAMMATORY CONDITIONS	SIMPONI	No	Included
ANTIHYPERLIPIDEMIC	TRYNGOLZA	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	STEQEYMA	No	Included
ASTHMA	NUCALA	Yes	Included	INFLAMMATORY CONDITIONS	TALTZ	No	Included
ASTHMA	TEZSPIRE	Yes	Included	INFLAMMATORY CONDITIONS	TREMFYA	No	Included
ASTHMA	XOLAIR	Yes	Included	INFLAMMATORY CONDITIONS	TYENNE	No	Included
CARDIOVASCULAR	ATTRUBY	Yes	Included	INFLAMMATORY CONDITIONS	VELSIPITY	No	Included
CARDIOVASCULAR	CAMZYOS	Yes	Included	INFLAMMATORY CONDITIONS	WEZLANA	No	Included
CARDIOVASCULAR	DROXIDOPA	No	Included	INFLAMMATORY CONDITIONS	XELJANZ	No	Included
CARDIOVASCULAR	NORTHERA	Yes	Included	INFLAMMATORY CONDITIONS	XELJANZ XR	No	Included
CARDIOVASCULAR	VYNDAMAX	Yes	Included	INFLAMMATORY CONDITIONS	YESINTEK	No	Included
CARDIOVASCULAR	VYNDAEQEL	Yes	Included	INFLAMMATORY CONDITIONS	YUFLYMA	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	AUSTEDO	No	Included	INFLAMMATORY CONDITIONS	YUSIMRY	No	Included

CENTRAL NERVOUS SYSTEM AGENTS	ENSPRYNG	Yes	Included	INFLAMMATORY CONDITIONS	ZYMFENTRA	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	FIRDAPSE	Yes	Included	IRON OVERLOAD	DEFERASIROX	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	HETLIOZ	Yes	Included	IRON OVERLOAD	DEFERIPRONE	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	INGREZZA	Yes	Included	IRON OVERLOAD	EXJADE	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	RADICAVA	Yes	Included	IRON OVERLOAD	FERRIPROX	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	RILUZOLE	No	Included	IRON OVERLOAD	JADENU	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	SABRIL	Yes	Included	METABOLIC AGENTS	MIPLYFFA	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	SKYCLARYS	Yes	Included	METABOLIC BONE DISEASE	SOHONOS	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	TASIMELTEON	Yes	Included	MOOD DISORDER DRUGS	SPRAVATO	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	TEGLUTIK	Yes	Included	MOOD DISORDER DRUGS	ZURZUVAE	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	TETRABENAZINE	No	Included	MULTIPLE SCLEROSIS	AMPYRA	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	TIGLUTIK	Yes	Included	MULTIPLE SCLEROSIS	AUBAGIO	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	VIGABATRIN	No	Included	MULTIPLE SCLEROSIS	AVONEX	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	VIGADRONE	Yes	Included	MULTIPLE SCLEROSIS	BAFIERTAM	Yes	Included
CENTRAL NERVOUS SYSTEM AGENTS	VIGPODER	Yes	Included	MULTIPLE SCLEROSIS	BETASERON	No	Included
CENTRAL NERVOUS SYSTEM AGENTS	XENAZINE	Yes	Included	MULTIPLE SCLEROSIS	COPAXONE	No	Included
CNS AGENTS	DAYBUE	Yes	Included	MULTIPLE SCLEROSIS	DALFAMPRIDIN	No	Included
CNS AGENTS	EXSERVAN	Yes	Included	MULTIPLE SCLEROSIS	DIMETHYL FUMARATE	No	Included
CNS AGENTS	RELYVIRIO	Yes	Included	MULTIPLE SCLEROSIS	EXTAVIA	No	Included
CNS AGENTS	RILUTEK	No	Included	MULTIPLE SCLEROSIS	FINGOLIMOD	No	Included
CYSTIC FIBROSIS	ALYFTREK	Yes	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	TERILFUMONIDE	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	CRENESSITY	Yes	Included	NARCOLEPSY	LUMRYZ	Yes	Included
ENDOCRINE	CTEXLI	Yes	Included	NARCOLEPSY	SODIUM OXYBATE	Yes	Included
ENDOCRINE	CUPRIMINE	No	Included	NARCOLEPSY	WAKIX	Yes	Included
ENDOCRINE	CUVRIOR	Yes	Included	NARCOLEPSY	XYREM	Yes	Included
ENDOCRINE	CYSTADANE	Yes	Included	NARCOLEPSY	XYWAV	Yes	Included
ENDOCRINE	DEPEN TITRATABS	No	Included	NEUTROPENIA	FULPHILA	No	Included
ENDOCRINE	EGRIFTA	Yes	Included	NEUTROPENIA	FYLNETRA	No	Included
ENDOCRINE	FIRMAGON	No	Included	NEUTROPENIA	GRANIX	No	Included
ENDOCRINE	IMCIVREE	Yes	Included	NEUTROPENIA	LEUKINE	No	Included
ENDOCRINE	ISTURISA	Yes	Included	NEUTROPENIA	NEULASTA	No	Included
ENDOCRINE	JAVYGTOR	Yes	Included	NEUTROPENIA	NEUPOGEN	No	Included
ENDOCRINE	JYNARQUE	Yes	Included	NEUTROPENIA	NIVESTYM	No	Included
ENDOCRINE	KORLYM	Yes	Included	NEUTROPENIA	NYVEPRIA	No	Included
ENDOCRINE	KUVAN	Yes	Included	NEUTROPENIA	RELEUKO	No	Included
ENDOCRINE	LANREOTIDE	No	Included	NEUTROPENIA	STIMUFEND	No	Included
ENDOCRINE	MIFEPRISTONE	Yes	Included	NEUTROPENIA	UDENYCA	No	Included
ENDOCRINE	MYALEPT	Yes	Included	NEUTROPENIA	ZARXIO	No	Included
ENDOCRINE	MYCAPSSA	Yes	Included	NEUTROPENIA	ZIEXTENZO	No	Included
ENDOCRINE	NATPARA	Yes	Included	ONCOLOGY - INJECTABLE	BESREMI	Yes	Included
ENDOCRINE	NITYR	Yes	Included	ONCOLOGY - INJECTABLE	ELIGARD	No	Included
ENDOCRINE	OCTREOTIDE ACETATE	No	Included	ONCOLOGY - INJECTABLE	INTRON A	Yes	Included
ENDOCRINE	PENICILLAMINE	No	Included	ONCOLOGY - INJECTABLE	LEUPROLIDE	No	Included
ENDOCRINE	PROCYSBI	Yes	Included	ONCOLOGY - INJECTABLE	SYNRIBO	Yes	Included
ENDOCRINE	RECORLEV	Yes	Included	ONCOLOGY - ORAL	ABIRATERONE	No	Included
ENDOCRINE	SAMSCA	Yes	Included	ONCOLOGY - ORAL	ABIRTEGA	No	Included
ENDOCRINE	SANDOSTATIN	No	Included	ONCOLOGY - ORAL	AFINITOR	No	Included
ENDOCRINE	SAPROTERIN	Yes	Included	ONCOLOGY - ORAL	AFINITOR DISPERZ	No	Included
ENDOCRINE	SIGNIFOR	Yes	Included	ONCOLOGY - ORAL	AKEEGA	Yes	Included
ENDOCRINE	SOMATULINE DEPOT	No	Included	ONCOLOGY - ORAL	ALECENSA	Yes	Included
ENDOCRINE	SOMAVERT	Yes	Included	ONCOLOGY - ORAL	ALKERAN	No	Included
ENDOCRINE	SYPRINE	No	Included	ONCOLOGY - ORAL	ALUNBRIG	Yes	Included

ENDOCRINE	THIOLA	Yes	Included	ONCOLOGY - ORAL	AUGTYRO	No	Included
ENDOCRINE	TIOPRONIN	No	Included	ONCOLOGY - ORAL	AYVAKIT	Yes	Included
ENDOCRINE	TOLVAPTAN	No	Included	ONCOLOGY - ORAL	BALVERSA	Yes	Included
ENDOCRINE	TRIENTINE	No	Included	ONCOLOGY - ORAL	BEXAROTENE	No	Included
ENDOCRINE	XURIDEN	Yes	Included	ONCOLOGY - ORAL	BOSULIF	Yes	Included
ENDOCRINE	YORVIPATH	Yes	Included	ONCOLOGY - ORAL	BRAFTOVI	Yes	Included
ENZYME DEFICIENCY	TEGSEDI	Yes	Included	ONCOLOGY - ORAL	BRUKINSA	Yes	Included
ENZYME THERAPY	BUPHENYL	No	Included	ONCOLOGY - ORAL	CABOMETYX	Yes	Included
ENZYME THERAPY	CARBAGLU	Yes	Included	ONCOLOGY - ORAL	CALQUENCE	Yes	Included
ENZYME THERAPY	CARGLUMIC	Yes	Included	ONCOLOGY - ORAL	CAPECITABINE	No	Included
ENZYME THERAPY	CERDELGA	Yes	Included	ONCOLOGY - ORAL	CAPRELSA	Yes	Included
ENZYME THERAPY	CHOLBAM	Yes	Included	ONCOLOGY - ORAL	COMETRIQ	Yes	Included
ENZYME THERAPY	CYSTAGON	Yes	Included	ONCOLOGY - ORAL	COPIKTRA	Yes	Included
ENZYME THERAPY	GALAFOLD	Yes	Included	ONCOLOGY - ORAL	COTELLIC	Yes	Included
ENZYME THERAPY	MIGLUSTAT	No	Included	ONCOLOGY - ORAL	DASATINIB	No	Included
ENZYME THERAPY	NITISINONE	No	Included	ONCOLOGY - ORAL	DAURISMO	Yes	Included
ENZYME THERAPY	OLPRUVA	Yes	Included	ONCOLOGY - ORAL	ERIVEDGE	Yes	Included
ENZYME THERAPY	OPFOLDA	Yes	Included	ONCOLOGY - ORAL	ERLEADA	No	Included
ENZYME THERAPY	ORFADIN	Yes	Included	ONCOLOGY - ORAL	ERLOTINIB	Yes	Included
ENZYME THERAPY	PALYNZIQ	Yes	Included	ONCOLOGY - ORAL	ETOPOSIDE	No	Included
ENZYME THERAPY	PHEBURANE	Yes	Included	ONCOLOGY - ORAL	EVEROLIMUS	No	Included
ENZYME THERAPY	SODIUM PHENYLBUTYRATE	No	Included	ONCOLOGY - ORAL	EXKIVITY	Yes	Included
ENZYME THERAPY	STRENSIQ	Yes	Included	ONCOLOGY - ORAL	FARYDAK	Yes	Included
ENZYME THERAPY	SUCRAID	Yes	Included	ONCOLOGY - ORAL	FOTIVDA	Yes	Included
ENZYME THERAPY	WAINUA	Yes	Included	ONCOLOGY - ORAL	FRUZAQLA	Yes	Included
ENZYME THERAPY	YARGESA	Yes	Included	ONCOLOGY - ORAL	GAVRETO	Yes	Included
ENZYME THERAPY	ZAVESCA	Yes	Included	ONCOLOGY - ORAL	GEFITINIB	No	Included
GASTROINTESTINAL AGENTS	GATTEX	Yes	Included	ONCOLOGY - ORAL	GILOTRIF	Yes	Included
GASTROINTESTINAL AGENTS	IQIRVO	Yes	Included	ONCOLOGY - ORAL	GLEEVEC	No	Included
GASTROINTESTINAL AGENTS	LIVDELZI	Yes	Included	ONCOLOGY - ORAL	GLEOSTINE	No	Included
GASTROINTESTINAL AGENTS	OCALIVA	Yes	Included	ONCOLOGY - ORAL	HYCAMTIN	No	Included
GASTROINTESTINAL AGENTS	VOWST	Yes	Included	ONCOLOGY - ORAL	IBRANCE	Yes	Included
GASTROINTESTINAL AGENTS	XERMELO	Yes	Included	ONCOLOGY - ORAL	ICLUSIG	Yes	Included
GENETIC DISORDER	DOJOLVI	Yes	Included	ONCOLOGY - ORAL	IDHIFA	No	Included
GENETIC DISORDER	RIVFLOZA	Yes	Included	ONCOLOGY - ORAL	IMATINIB MESYLATE	No	Included
GENETIC DISORDER	VUOICE	No	Included	ONCOLOGY - ORAL	IMBRUVICA	Yes	Included
GENETIC DISORDER	ZOKINVY	Yes	Included	ONCOLOGY - ORAL	IMKELDI	No	Included
GROWTH HORMONE DEFICIENCY	GENOTROPIN	No	Included	ONCOLOGY - ORAL	INLYTA	Yes	Included
GROWTH HORMONE DEFICIENCY	HUMATROPE	No	Included	ONCOLOGY - ORAL	INQOVI	Yes	Included
GROWTH HORMONE DEFICIENCY	INCRELEX	Yes	Included	ONCOLOGY - ORAL	INREBIC	Yes	Included
GROWTH HORMONE DEFICIENCY	NGENLA	No	Included	ONCOLOGY - ORAL	IRESSA	Yes	Included
GROWTH HORMONE DEFICIENCY	NORDITROPIN	No	Included	ONCOLOGY - ORAL	ITOVEBI	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	ALVAIZ	No	Included	ONCOLOGY - ORAL	LENVIMA	Yes	Included
HEMATOLOGICAL AGENTS	CABLVI	Yes	Included	ONCOLOGY - ORAL	LONSURF	Yes	Included
HEMATOLOGICAL AGENTS	DOPTELET	Yes	Included	ONCOLOGY - ORAL	LORBRENA	Yes	Included
HEMATOLOGICAL AGENTS	EMPAVELI	Yes	Included	ONCOLOGY - ORAL	LUMAKRAS	Yes	Included
HEMATOLOGICAL AGENTS	FABHALTA	Yes	Included	ONCOLOGY - ORAL	LYNPARZA	Yes	Included
HEMATOLOGICAL AGENTS	MOZOBI	No	Included	ONCOLOGY - ORAL	LYTGobi	Yes	Included
HEMATOLOGICAL AGENTS	MULPLETA	No	Included	ONCOLOGY - ORAL	MATULANE	Yes	Included
HEMATOLOGICAL AGENTS	PLERIXAFOR	No	Included	ONCOLOGY - ORAL	MEKINIST	No	Included
HEMATOLOGICAL AGENTS	PROMACTA	No	Included	ONCOLOGY - ORAL	MEKTOVI	Yes	Included
HEMATOLOGICAL AGENTS	PYRUKYND	Yes	Included	ONCOLOGY - ORAL	MELPHALAN	No	Included
HEMATOLOGICAL AGENTS	REZUROCK	Yes	Included	ONCOLOGY - ORAL	MERCAPTOPYRINE	No	Included
HEMATOLOGICAL AGENTS	TAVALISSE	Yes	Included	ONCOLOGY - ORAL	MESNA	No	Included
HEMOPHILIA - INFUSED	ADVATE	No	Included	ONCOLOGY - ORAL	MESNEX	No	Included
HEMOPHILIA - INFUSED	ADYNOVATE	No	Included	ONCOLOGY - ORAL	NERLYNX	Yes	Included
HEMOPHILIA - INFUSED	AFSTYLA	No	Included	ONCOLOGY - ORAL	NEXAVAR	Yes	Included
HEMOPHILIA - INFUSED	ALPHANATE/VON WILLEBRAND	No	Included	ONCOLOGY - ORAL	NILANDRON	No	Included
HEMOPHILIA - INFUSED	ALPHANINE SD	No	Included	ONCOLOGY - ORAL	NILUTAMIDE	No	Included
HEMOPHILIA - INFUSED	ALPROLIX	No	Included	ONCOLOGY - ORAL	NINLARO	No	Included
HEMOPHILIA - INFUSED	ALTUVIIIO	No	Included	ONCOLOGY - ORAL	NUBEQA	Yes	Included
HEMOPHILIA - INFUSED	BENEFIX	No	Included	ONCOLOGY - ORAL	ODOMZO	No	Included
HEMOPHILIA - INFUSED	COAGADEX	Yes	Included	ONCOLOGY - ORAL	OGSIVEO	Yes	Included
HEMOPHILIA - INFUSED	CORIFACT	No	Included	ONCOLOGY - ORAL	OJEMDA	Yes	Included
HEMOPHILIA - INFUSED	ELOCTATE	No	Included	ONCOLOGY - ORAL	OJJAARA	Yes	Included
HEMOPHILIA - INFUSED	ESPEROCT	No	Included	ONCOLOGY - ORAL	ONUREG	No	Included
HEMOPHILIA - INFUSED	FEIBA	No	Included	ONCOLOGY - ORAL	ORGOVYX	Yes	Included
HEMOPHILIA - INFUSED	HEMOFIL M	No	Included	ONCOLOGY - ORAL	ORSERDU	Yes	Included
HEMOPHILIA - INFUSED	HUMATE-P	No	Included	ONCOLOGY - ORAL	PAZOPANIB	Yes	Included
HEMOPHILIA - INFUSED	IDELVION	No	Included	ONCOLOGY - ORAL	PEMAZYRE	Yes	Included
HEMOPHILIA - INFUSED	IXINITY	No	Included	ONCOLOGY - ORAL	PIQRAY	No	Included
HEMOPHILIA - INFUSED	JIVI	No	Included	ONCOLOGY - ORAL	POMALYST	Yes	Included
HEMOPHILIA - INFUSED	KOATE	No	Included	ONCOLOGY - ORAL	PURIXAN	No	Included
HEMOPHILIA - INFUSED	KOATE-DVI	No	Included	ONCOLOGY - ORAL	QINLOCK	Yes	Included
HEMOPHILIA - INFUSED	KOGENATE FS	No	Included	ONCOLOGY - ORAL	RETEVMO	Yes	Included

HEMOPHILIA - INFUSED	KOALTRY	No	Included	ONCOLOGY - ORAL	REVLIMID	Yes	Included
HEMOPHILIA - INFUSED	MONONINE	No	Included	ONCOLOGY - ORAL	REZLIDHIA	Yes	Included
HEMOPHILIA - INFUSED	NOVOEIGHT	No	Included	ONCOLOGY - ORAL	ROZLYTREK	No	Included
HEMOPHILIA - INFUSED	NOVOSEVEN RT	No	Included	ONCOLOGY - ORAL	RUBRACA	Yes	Included
HEMOPHILIA - INFUSED	NUWIQ	No	Included	ONCOLOGY - ORAL	RYDAPT	No	Included
HEMOPHILIA - INFUSED	OBIZUR	No	Included	ONCOLOGY - ORAL	SCEMBLIX	Yes	Included
HEMOPHILIA - INFUSED	PROFILNINE	No	Included	ONCOLOGY - ORAL	SORAFENIB	No	Included
HEMOPHILIA - INFUSED	REBINYN	No	Included	ONCOLOGY - ORAL	SPRYCEL	No	Included
HEMOPHILIA - INFUSED	RECOMBINATE	No	Included	ONCOLOGY - ORAL	STIVARGA	Yes	Included
HEMOPHILIA - INFUSED	RIXUBIS	No	Included	ONCOLOGY - ORAL	SUNITINIB	Yes	Included
HEMOPHILIA - INFUSED	SEVENFACT	No	Included	ONCOLOGY - ORAL	SUTENT	Yes	Included
HEMOPHILIA - INFUSED	TRETEN	Yes	Included	ONCOLOGY - ORAL	TABLOID	No	Included
HEMOPHILIA - INFUSED	VONVENDI	Yes	Included	ONCOLOGY - ORAL	TABRECTA	No	Included
HEMOPHILIA - INFUSED	WILATE	No	Included	ONCOLOGY - ORAL	TAFINLAR	No	Included
HEMOPHILIA - INFUSED	XYNTHA	No	Included	ONCOLOGY - ORAL	TAGRISSE	Yes	Included
HEMOPHILIA - INJECTABLE	ALHEMO	No	Included	ONCOLOGY - ORAL	TALZENNA	Yes	Included
HEMOPHILIA - INJECTABLE	HEMLIBRA	Yes	Included	ONCOLOGY - ORAL	TARCEVA	Yes	Included
HEMOPHILIA - INJECTABLE	HYMPAVZI	No	Included	ONCOLOGY - ORAL	TARGETIN	No	Included
HEPATITIS C	EPCLUSA	No	Included	ONCOLOGY - ORAL	TASIGNA	Yes	Included
HEPATITIS C	HARVONI	No	Included	ONCOLOGY - ORAL	TAZVERIK	Yes	Included
HEPATITIS C	LEDIPASVIR/SOFOSBUVIR	No	Included	ONCOLOGY - ORAL	TEMODAR	No	Included
HEPATITIS C	MAVYRET	No	Included	ONCOLOGY - ORAL	TEMOZOLOMIDE	No	Included
HEPATITIS C	PEGASYS	No	Included	ONCOLOGY - ORAL	TEPMETKO	Yes	Included
HEPATITIS C	SOFOSBUVIR/VELPATASVIR	No	Included	ONCOLOGY - ORAL	THALOMID	Yes	Included
HEPATITIS C	SOVALDI	No	Included	ONCOLOGY - ORAL	TIBSOVO	Yes	Included
HEPATITIS C	VIEKIRA PAK	No	Included	ONCOLOGY - ORAL	TORPENZ	Yes	Included
HEPATITIS C	VOSEVI	No	Included	ONCOLOGY - ORAL	TRETINOIN	No	Included
HEPATITIS C	ZEPATIER	No	Included	ONCOLOGY - ORAL	TRUQAP	Yes	Included
HEPATOLOGY	BYLVAY	Yes	Included	ONCOLOGY - ORAL	TRUSELTIQ	Yes	Included
HEPATOLOGY	LIVMARLI	Yes	Included	ONCOLOGY - ORAL	TUKYSA	Yes	Included
HEREDITARY ANGIOEDEMA	BERINERT	Yes	Included	ONCOLOGY - ORAL	TURALIO	Yes	Included
HEREDITARY ANGIOEDEMA	CINRYZE	Yes	Included	ONCOLOGY - ORAL	TYKERB	No	Included
HEREDITARY ANGIOEDEMA	FIRAZYR	Yes	Included	ONCOLOGY - ORAL	VANFLYTA	Yes	Included
HEREDITARY ANGIOEDEMA	HAEGARDA	Yes	Included	ONCOLOGY - ORAL	VENCLEXTA	Yes	Included
HEREDITARY ANGIOEDEMA	ICATIBANT	No	Included	ONCOLOGY - ORAL	VERZENIO	Yes	Included
HEREDITARY ANGIOEDEMA	ORLADEYO	Yes	Included	ONCOLOGY - ORAL	VITRAKVI	Yes	Included
HEREDITARY ANGIOEDEMA	RUCONEST	Yes	Included	ONCOLOGY - ORAL	VIZIMPRO	Yes	Included
HEREDITARY ANGIOEDEMA	SAJAZIR	Yes	Included	ONCOLOGY - ORAL	VONJO	Yes	Included
HEREDITARY ANGIOEDEMA	TAKHZYRO	Yes	Included	ONCOLOGY - ORAL	VOTRIENT	Yes	Included
IGA NEPHROPATHY	FILSPARI	Yes	Included	ONCOLOGY - ORAL	WELIREG	Yes	Included
IGA NEPHROPATHY	TARPEYO	Yes	Included	ONCOLOGY - ORAL	XALKORI	Yes	Included
IMMUNOLOGICAL AGENTS	ACTIMMUNE	Yes	Included	ONCOLOGY - ORAL	XELODA	No	Included
IMMUNOLOGICAL AGENTS	ARCALYST	Yes	Included	ONCOLOGY - ORAL	XOSPATA	Yes	Included
IMMUNOLOGICAL AGENTS	BENLYSTA	Yes	Included	ONCOLOGY - ORAL	XPOVIO	Yes	Included
IMMUNOLOGICAL AGENTS	JOENJA	Yes	Included	ONCOLOGY - ORAL	XTANDI	Yes	Included
IMMUNOLOGICAL AGENTS	LUPKYNIS	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	TARGETIN	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	PREGNLY	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-ADB	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	AMBRISANTAN	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	OPSYNVI	Yes	Included
INFLAMMATORY CONDITIONS	EBGLYSS	No	Included	PULMONARY HYPERTENSION	ORENITRAM	Yes	Included
INFLAMMATORY CONDITIONS	ENBREL	No	Included	PULMONARY HYPERTENSION	REVATIO	No	Included
INFLAMMATORY CONDITIONS	ENTYVIO	No	Included	PULMONARY HYPERTENSION	SILDENAFIL	No	Included
INFLAMMATORY CONDITIONS	H.P. ACTHAR	Yes	Included	PULMONARY HYPERTENSION	TADALAFIL	No	Included
INFLAMMATORY CONDITIONS	HADLIMA	No	Included	PULMONARY HYPERTENSION	TADLIQ	Yes	Included
INFLAMMATORY CONDITIONS	HULIO	No	Included	PULMONARY HYPERTENSION	TRACLEER	Yes	Included
INFLAMMATORY CONDITIONS	HUMIRA	No	Included	PULMONARY HYPERTENSION	TYVASO	Yes	Included

INFLAMMATORY CONDITIONS	HYRIMOZ	No	Included	PULMONARY HYPERTENSION	UPTRAVI	Yes	Included
INFLAMMATORY CONDITIONS	IDACIO	No	Included	PULMONARY HYPERTENSION	VENTAVIS*	Yes	Included
INFLAMMATORY CONDITIONS	ILUMYA	No	Included	PULMONARY HYPERTENSION	WINREVAIR	Yes	Included
INFLAMMATORY CONDITIONS	KEVZARA	No	Included	WOUND MANAGEMENT	FILSUVEZ	Yes	Included
INFLAMMATORY CONDITIONS	KINERET	Yes	Included				

*Includes Nebulizer
2Q 2025

Generic equivalents may be dispensed in lieu of brands.



UnitedHealthcare®

P.O. Box 510941
Livonia, MI 48151-6941

[To the parent(s)/guardian(s) of]

<MEMBER_FIRST_NAME> <MEMBER_LAST_NAME>

<MEMBER_ADDRESS1>

<MEMBER_ADDRESS2>

<MEMBER_CITY>, <MEMBER_STATE> <MEMBER_ZIPCODE>

**Important information about
your pharmacy benefits
starting <CHANGE_CODE_EFFECTIVE_DATE>.**

Month DD, YYYY

Dear <MEMBER_FIRST_NAME>,

We want to let you know about a change to your prescription drug coverage.

Starting <CHANGE_CODE_EFFECTIVE_DATE>, OptumRx will manage pharmacy care services for <PLAN_NAME> plan.

Starting <CHANGE_CODE_EFFECTIVE_DATE>, you will need prior authorization (PA) for the drug(s) below.

A PA is an approval we give your doctor before the drug(s) can be covered. The PA process helps determine if a drug meets coverage requirements. A drug may need PA to make sure it is used to effectively treat conditions.

Drug requiring a PA
<TARGET_MED>
<TARGET_MED2>
<TARGET_MED3>
<TARGET_MED4>
<TARGET_MED5>
<TARGET_MED6>
<TARGET_MED7>
<TARGET_MED8>
<TARGET_MED9>
<TARGET_MED10>

What do I need to do?

Please talk to your doctor as soon as possible. If your doctor wants you to keep taking the drug(s) above, you or your doctor can ask us for a PA. If the PA is approved, you may keep filling your prescription(s) as usual.

If the PA is not approved and you fill a prescription after **<CHANGE_CODE_EFFECTIVE_DATE>**, you may have to pay the full cost of the drug(s). The amount you pay will not count toward any deductible or out-of-pocket limit you may have.

If you don't take action, coverage for your next refill may be delayed. In some situations, coverage may be extended if you need extra time to review your options with your doctor.

Questions? We'll be here to help.

- Call **<TFN>**

We look forward to serving you.

Sincerely,

The UnitedHealthcare Team



If you are no longer a member of this health plan after the effective date of these changes, please disregard this letter.

Always refer to your benefit plan materials to determine coverage for medications and copayments. Some medications listed on the Prescription Drug List may not be covered under your specific benefit. When there are differences, the benefit plan documents will rule.

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Legal Entity
Service Center
Address
City, State, ZIP Code

Explanation of Benefits

Member/Patient: ROBERT TEST
Member ID: A123456789
Relationship: EE
Group name: TEST CUSTOMER
Group number: 0123456

ROBERT TEST
Address
City, State, ZIP Code

Hi, ROBERT.

THIS IS NOT A BILL. This Explanation of Benefits (EOB) is a summary of services received and how plan benefits were applied.

To the right is the total amount you may owe for the services included in this statement – but, depending on when you receive this statement, that amount may not reflect payments you’ve already made. Visit myuhc.com to see the most up to date amounts.

Use this EOB as a reference or retain as needed.

Services in this statement occurred between Sep. 1, 2023 - Sep. 1, 2023

Provider billed	\$320.66
Your total amount owed	\$153.68

See claim details on following pages or go directly to myuhc.com to view.



Plan balances

As of 09/21/2023 for plan year 2023

Balances for ROBERT		Maximum amount	Progress so far	Remaining amount
Network	Deductible	\$1,000.00	\$1,000.00	Met
	Out-of-pocket limit	\$6,500.00	\$4,996.35	\$1,503.65
Out-of-Network	Deductible	\$5,000.00	\$95.00	\$4,905.00
	Out-of-pocket limit	\$10,000.00	\$95.00	\$9,905.00

Got questions?

Get in touch with customer service at **888-888-8888**



Plan balances continued

As of 09/21/2023 for plan year 2023

Balances for FAMILY

		Maximum amount	Progress so far	Remaining amount
Network	Deductible	\$2,000.00	\$1,000.00	\$1,000.00
	Out-of-pocket limit	\$13,000.00	\$4,996.35	\$8,003.65
Out-of-Network	Deductible	\$10,000.00	\$95.00	\$9,905.00
	Out-of-pocket limit	\$20,000.00	\$95.00	\$19,905.00



Definitions of Key Terms

Amount saved: You do not owe this amount because either (1) you chose a network provider that gives us a standing discount, (2) you chose an out-of-network provider that agreed to an amount less than billed, or (3) it is a surprise bill and the law protects you from having to pay it.

Amount you owe: The amount of money you pay for the services you receive.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the amount for the service.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Plan does not cover: A service or expense that you do not have coverage for under your health benefit plan.

Got questions?

Get in touch with customer service at **888-888-8888**

Claim detail for ROBERT

Provider: TEST
Status: Network

Patient account number: C10000000000
Claim number: EC0123456701

		Billed	Savings and plan allowed amount		Amounts paid	Total you owe				
Services received	Claim processing codes	Provider billed	Amount saved	Plan allowed amount	Your plan paid	Applied to deductible	Copay	Coinsurance	Plan does not cover	Amount you owe**
RADIOLOGY SERVICES 09/01/2023	UG	\$161.98	\$84.85	\$77.13	\$0.00	\$77.13	\$0.00	\$0.00	\$0.00	\$77.13
RADIOLOGY SERVICES 09/01/2023	2Q	\$132.70	\$70.27	\$62.43	\$0.00	\$62.43	\$0.00	\$0.00	\$0.00	\$62.43
RADIOLOGY SERVICES 09/01/2023	UG	\$25.98	\$11.86	\$14.12	\$0.00	\$14.12	\$0.00	\$0.00	\$0.00	\$14.12
Total amount		\$320.66	\$166.98	\$153.68	\$0.00	\$153.68	\$0.00	\$0.00	\$0.00	\$153.68

**This amount may not reflect payments made to the provider at the time of service, and it will not include any payments directly made to the subscriber (except for when coordination of benefits applies). You/the subscriber may be responsible for paying the physician, facility or other healthcare professional directly. We recommend you hold off on making any payments until you receive the bill from the provider.

Explanation of your claim processing codes

Claim processing codes are used to identify specific types of adjustments relating to your claims. The corresponding details will help explain how your claim was processed.

2Q – THE AMOUNT ALLOWED FOR THIS SERVICE HAS BEEN REDUCED BASED ON THE MULTIPLE PROCEDURE PAYMENT REDUCTION FOR DIAGNOSTIC IMAGING POLICY. THE MAXIMUM AMOUNT WAS ALLOWED.

UG – YOU HAVE RECEIVED A DISCOUNT FOR USING A HEALTH CARE PROFESSIONAL IN YOUR PLAN'S NETWORK. YOU HAVE NOT MET YOUR DEDUCTIBLE YET AND OWE THE AMOUNT SHOWN. PROVIDER: THE MEMBER HAS NOT MET THE PLAN DEDUCTIBLE AND IS RESPONSIBLE FOR THE AMOUNT SHOWN.

Got questions?

Get in touch with customer service at **888-888-8888**



Service Center
Address
City, State, ZIP Code

Your rights as a member

Requesting an appeal to a decision

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432, Salt Lake City, UT 84130-0432. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

Availability of Consumer Assistance/Ombudsman Services

There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.dol.gov. If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

Got questions?

Get in touch with customer service at **888-888-8888**

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09/21/2023

If your claim is subject to the No Surprises Act, additional information about your rights will be available at the end of this statement.

If you believe you have been wrongly billed by your provider, you may contact Idaho Department of Insurance by visiting the department's website at doi.idaho.gov/nosurprises or calling the Consumer Affairs section at 1-208-334-4319 or toll-free in Idaho at 1-800-721-3272. Visit doi.idaho.gov/nosurprises for more information about your rights under this law.

Fighting healthcare fraud

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 844-333-8728.

Privacy

Maintaining the privacy and security of individuals' personal information is very important to us at UnitedHealthcare. To protect your privacy, we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier. You may see the unique individual identifier on UnitedHealthcare correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBs), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer service professional at the number shown at the top of this Statement.

United
Healthcare®

Service Center
Address
City, State, ZIP Code

Your rights as a member continued

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you weren't treated fairly you can send a complaint to: Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608, Salt Lake City, UTAH 84130, UHC_Civil_Rights@uhc.com. You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services. Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

Got questions?

Get in touch with customer service at **888-888-8888**

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PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániit'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqódi ninaaltsoos nit'izi bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'i biká'ígíí bee hodíilnih.

Additional Resources

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

Rather view this online?

Sign up for myuhc.com or download the UnitedHealthcare app to easily view claims and account balances, see where you're at against your deductible, locate a network doctor, view your health plan ID card and more. You can also skip the clutter by selecting paperless delivery of your important plan documents.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

United
Healthcare®



2300 Main Street CA134-0404
Irvine, CA 92614

<Provider_FULL_NAME_FORMATTED> <Target_Provider_Unq_ID>
<Target_Provider_Address1>
<Target_Provider_Address2>
<Target_Provider_City>, <Target_Provider_State> <Target_Provider_Zip_Code>

<Report_Date>

Re: Confidential: Your Patients Use of Opioid Analgesics

Dear <<Provider_FULL_NAME_FORMATTED>>:

The enclosed document provides information about your patients who have received opioid analgesic prescriptions from you and two or more other prescribers for nine or more prescriptions during the most recent calendar quarter. If you suspect your patients may be abusing these medications, please consider referring them to behavioral health counseling.

We obtained this information from pharmacy claims data and your name was transmitted to us by the dispensing pharmacies. If you believe you are receiving this information by mistake, please send a note to UnitedHealthcare pharmacy services via our confidential fax number at 888-203-1876 or call 1-877-399-0335.

Sincerely,

A handwritten signature in black ink that reads 'Susan V. Maddux'.

Susan V. Maddux, Pharm.D.
Chief Pharmacy Officer

Enclosures

SR10982451

This document and others if attached contain information from OptumRx that is privileged, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable

law. The information in this document is for the sole use of the person(s) or company named above. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to OptumRx Privacy Office, 17900 Von Karman, M/S CA016-0203, Irvine, CA 92614. Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.



Prescriber: <<Provider_FULL_NAME_FORMATTED>>

Identification Period: <<Identification_Period>>

Member: <<Member_First_Name> < Member_Last_Name>> **DOB:** <<Date_of_Birth >> **Member ID:** <<Member_ID>>

Fill Date	Drug	Quantity	Days Supplied	Prescriber	Pharmacy	Pharmacy Phone Number
<Claim_Fill_Date>	<Claim_Drug_Display_Name>	<Drug_Quantity>	<Days_Supply>	<Claim_Provider_Name>	<Claim_Pharmacy_Name>	<Claim_Pharmacy_Phone >
<Claim_Fill_Date>	<Claim_Drug_Display_Name>	<Drug_Quantity>	<Days_Supply>	<Claim_Provider_Name>	<Claim_Pharmacy_Name>	<Claim_Pharmacy_Phone >
<Claim_Fill_Date>	<Claim_Drug_Display_Name>	<Drug_Quantity>	<Days_Supply>	<Claim_Provider_Name>	<Claim_Pharmacy_Name>	<Claim_Pharmacy_Phone >
<Claim_Fill_Date>	<Claim_Drug_Display_Name>	<Drug_Quantity>	<Days_Supply>	<Claim_Provider_Name>	<Claim_Pharmacy_Name>	<Claim_Pharmacy_Phone >
<Claim_Fill_Date>	<Claim_Drug_Display_Name>	<Drug_Quantity>	<Days_Supply>	<Claim_Provider_Name>	<Claim_Pharmacy_Name>	<Claim_Pharmacy_Phone >

SR10982451 <Target_Provider_Unq_ID>

This document and others if attached contain information from OptumRx that is privileged, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to OptumRx Privacy Office, 17900 Von Karman, M/S CA016-0203, Irvine, CA 92614. Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

Data for patient identification is obtained from the member's most currently available pharmacy claims, as provided by the plan's pharmacy benefit manager, OptumRx, a UnitedHealth Group® Company.



SUMMARY PLAN DESCRIPTION

**Sample Company
Choice Plan**

Effective: January 1, 2023

Group Number: XXXXXX



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Amendments, Riders and Notices (As Applicable)

Amendment: Real Appeal

Amendment: UnitedHealthcare Motion

Amendment: Wellness

Outpatient Prescription Drug Plan Schedule of Benefits

Federal Notice

Summary Plan Description

United HealthCare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Health Care Services available to you under the Sample Company ("Plan Sponsor") Self-Funded health benefit plan. This *SPD* is a legal document that describes Benefits for the portion of the Plan for which United HealthCare Services, Inc. ("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD*, the Plan includes:

- The *Schedule of Benefits*.
- Amendments.
- Addendums.
- Summary Material Modification (SMM).

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, SMM or Amendment.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

On its effective date, this *SPD* replaces and overrules any *SPD* that the Plan Sponsor may have previously issued to you. This *SPD* will in turn be overruled by any *SPD* issued to you in the future.

The Plan will take effect on the date shown in the Plan. Coverage under the Plan starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not an employee health and welfare plan as defined by ERISA.

Introduction to Your SPD

This *SPD* and the other Plan documents describe your Benefits, as well as your rights and responsibilities, under the Plan.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms*.

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *SPD* and any attached Summary Material Modifications (SMMs) and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *SPD* at www.myuhc.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as an Employee or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Plan Sponsor may require you to make certain payments to them, in order for you to remain enrolled under the Plan. If you have questions about this, contact your Plan Sponsor.

Be Aware the Plan Does Not Pay for All Health Care Services

The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. The Plan will pay Benefits as of the day your coverage begins under the Plan for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

Plan Sponsor and the Claims Administrator make administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. Plan Sponsor's and the Claims Administrator's decisions are for payment purposes only. Plan Sponsor and the Claims Administrator do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Plan Sponsor and the Claims Administrator have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and any SMMs and/or Amendments.
- Make factual determinations relating to Benefits.

Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers

The Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings the Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to the Claims Administrator's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

The Claims Administrator may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but it is recommended that you discuss them with your Physician.

UnitedHealthcare Choice Plus

United HealthCare Services, Inc.

Schedule of Benefits

How Do You Access Benefits?

You can choose to receive Designated Network Benefits or Network Benefits or Out-of-Network Benefits.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Benefits.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Ground Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a plan year basis.

Out-of-Pocket Limits are calculated on a plan year basis.

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated.

Benefit limits are calculated on a plan year basis unless otherwise specifically stated.

Payment Term and Description Table

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this <i>Schedule of Benefits</i>, including Covered Health Care Services provided under the <i>Outpatient Prescription Drug Plan</i>. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table. Any amount that you pay for Covered Health	Designated Network For single coverage, the Annual Deductible is \$XX. If more than one person in a family is covered under the Plan, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$XX. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied. Network For single coverage, the Annual Deductible is \$XX. If more than one person in a family is covered under the Plan, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$XX. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.

Payment Term And Description	Amounts
Care Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Care Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.	
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Plan as indicated in this <i>Schedule of Benefits</i>, including Covered Health Care Services provided under the <i>Outpatient Prescription Drug Plan</i>. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: - Any charges for non-Covered Health Care Services. - Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. - Copayments or Coinsurance for any Covered Health Care Service shown in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Limit. - Copayments or Coinsurance for Covered Health Care Services provided under the <i>Outpatient Prescription Drug Plan</i>. Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	Designated Network For single coverage, the Out-of-Pocket Limit is \$XX. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is \$XX. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible. Network For single coverage, the Out-of-Pocket Limit is \$XX. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is \$XX. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible.

Payment Term And Description	Amounts
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.	

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 9: *Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Acupuncture Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Limited to XX treatments per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Ambulance Services		
Prior Authorization Requirement		
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation.		
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or	Ground Ambulance None Air Ambulance XX%	Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under Allowed Amounts in this Schedule of Benefits.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	<i>Ground Ambulance</i> Yes <i>Air Ambulance</i> Yes	
Does the Annual Deductible Apply?	<i>Ground Ambulance</i> Yes <i>Air Ambulance</i> No	
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	<i>Ground Ambulance</i> XX% <i>Air Ambulance</i> XX%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	<i>Ground Ambulance</i> Yes <i>Air Ambulance</i> Yes	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .
Does the Annual Deductible Apply?	<i>Ground Ambulance</i> No <i>Air Ambulance</i> Yes	
Cellular and Gene Therapy		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each	Cellular or Gene Therapy services must be received from a Designated Provider.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	Covered Health Care Service category in this <i>Schedule of Benefits</i> .	
Clinical Trials		
Designated Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>. Benefits are available when the Covered Health Care Services are provided by either Network or out-of-Network providers.
Congenital Heart Disease (CHD) Surgeries		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes	

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network	
Dental Services - Accident Only		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Limited to \$3,000 per year. Benefits are further limited to a maximum of \$900 per tooth.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network No	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	this <i>Schedule of Benefits</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	
Diabetes Self-Management Items What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME)</i>, <i>Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Plan</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME)</i>, <i>Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Plan</i>.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under <i>Durable Medical Equipment (DME)</i> , <i>Orthotics and Supplies</i> .
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Plan</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Plan</i>.	
Does the Annual Deductible Apply?	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Plan</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Plan</i>.	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every five years.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	You must obtain the DME from the vendor the Claims Administrator identifies or from the prescribing Network Physician.
Does the Annual Deductible Apply?	Designated Network No Network Yes	
Emergency Health Care Services - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes, after the Per Occurrence Deductible of \$XX per visit is satisfied	If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under Hospital - Inpatient Stay will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
		Care Services provided by an out-of-Network provider will be determined as described below under Allowed Amounts in this Schedule of Benefits.
Fertility Preservation for Iatrogenic Infertility		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Benefit limits will be the same as, and combined with, those stated under <i>Infertility Services</i> . This Benefit limit also includes services as described under <i>Preimplantation Genetic Testing (PGT) and Related Services</i> . Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network No	
Gender Dysphoria		
It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Plan</i> .	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Plan</i>.	
Habilitative Services		
Inpatient	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under <i>Skilled Nursing Facility/Inpatient Rehabilitation Services</i>.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Outpatient therapies: - Physical therapy. - Occupational therapy. - Manipulative Treatment. - Speech therapy. - Post-cochlear implant aural therapy.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network No	
Hearing Aids		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Limited to \$XX every year. Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Home Health Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Limited to XX visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Hospice Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Hospital - Inpatient Stay		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Infertility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Limited to \$XX per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Plan</i> . This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below. Benefits for Assisted Reproductive Technology (ART) are limited to one procedure during the entire period of time a Covered Person is enrolled under the Plan.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network No Network Yes	
Lab, X-Ray and Diagnostic - Minor Outpatient Services		
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment.	Designated Network None Network XX%	Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None <i>Partial Hospitalization/Intensive Outpatient Treatment</i> XX% for Partial Hospitalization/Intensive Outpatient Treatment None for visits for medication management Network XX% <i>Partial Hospitalization/Intensive Outpatient Treatment</i> None for Partial Hospitalization/Intensive Outpatient Treatment None for visits for medication management	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes <i>Partial Hospitalization/Intensive Outpatient Treatment</i> Yes Network Yes <i>Partial Hospitalization/Intensive Outpatient Treatment</i> Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Designated Network Yes <i>Partial Hospitalization/ Intensive Outpatient Treatment</i> Yes Network Yes <i>Partial Hospitalization/ Intensive Outpatient Treatment</i> Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network AbleTo Therapy360 Program None	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Obesity - Weight Loss Surgery		
It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.		
	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each	Benefits are limited to \$XX during the entire period of time a Covered Person is enrolled for coverage under the Plan.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	Covered Health Care Service category in this <i>Schedule of Benefits</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	
Orthopedic Surgeries		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, implant fees, DME and supplies and non-surgical management of spine and joint services will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Ostomy Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Limited to \$XX per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Pharmaceutical Products - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes, except when provided during a Physician office visit Network Yes, except when provided	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	during a Physician office visit	
Physician Fees for Surgical and Medical Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Allowed Amounts for Covered Health Care Services provided by an out-of-Network facility based Physician in a Network facility will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Physician's Office Services - Sickness and Injury		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% None for allergy injections when no other service is provided during the office visit Network XX% None for allergy injections when no other service is provided during the office visit	In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>. • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Outpatient Pharmaceutical Products

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Pregnancy - Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Designated Network Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Network Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Preimplantation Genetic Testing (PGT) and Related Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None XX%	Benefit limits will be the same as, and combined with, those stated under <i>Infertility Services</i> . This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This Benefit limit also includes services as described under <i>Fertility Preservation for Iatrogenic Infertility</i> . Benefits for Assisted Reproductive Technology (ART) for related services as described under <i>Infertility Services</i> do not include the Preimplantation genetic testing for the specific genetic disorder.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Preventive Care Services		
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	

Sample Company Medical and Outpatient Prescription Drugs Plan

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Prosthetic Devices		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Benefits are limited to a single purchase of each type of prosthetic device every year. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of</i>

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Reconstructive Procedures		
	Designated Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Limited per year as follows: • XX visits of physical therapy. • XX visits of occupational therapy. • XX Manipulative Treatments. • XX visits of speech therapy.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network No	
Scolpic Procedures - Outpatient Diagnostic and Therapeutic		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Limited to XX days per year.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Surgery - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes, after the Per Occurrence Deductible of \$XX per date of service is satisfied Network Yes, after the Per Occurrence Deductible of \$XX per date of service is satisfied	
Temporomandibular Joint (TMJ) Services		
	Designated Network Depending upon where the Covered Health Care Service is provided.	Limited to \$XX per year.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
	Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>. Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	
Therapeutic Treatments - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Urgent Care Center Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostic - Outpatient</i>. • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i> .
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Urinary Catheters		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network XX% Network None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	

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Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	
Virtual Care Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Network None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Network Yes	
Does the Annual Deductible Apply?	Network Yes	
Vision Exams		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Network XX%	Limited to 1 exam every XX years.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Network Yes	
Does the Annual Deductible Apply?	Network Yes	

Covered Health Care Service	The Amount You Pay Designated Network and Network	What are the Limitations & Exceptions?
Wigs		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Designated Network None Network XX%	Limited to \$XX per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Designated Network Yes Network Yes	
Does the Annual Deductible Apply?	Designated Network Yes Network Yes	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
 - For Covered Health Care Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians**, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
 - For Covered Health Care Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
 - For Covered Health Care Services that are **Emergency Health Care Services provided by an out-of-Network provider**, you are not responsible, and the out-of-Network provider may

not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

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

Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are negotiated by the Claims Administrator or an amount permitted by law.

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.

- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

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

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law
 - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

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

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

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

Advocacy Services

Your Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to out-of-Network providers that have questions about the Allowed Amount and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Allowed Amount, and the Claims Administrator, or its designee, believes that it would serve the best interests of the Plan and its Employees (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Allowed Amount for that particular claim.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not Sample Company or the Claims Administrator's employees. It is your responsibility to choose your provider.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claims Administrator's products. Refer to your provider directory or contact the Claims Administrator for help.

Designated Providers

If you have a medical condition that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Care Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, the Plan may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

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

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount of the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Sample Company Medical and Outpatient Prescription Drugs Plan

- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - The clinically appropriate monitoring of the effects of the service or item, or
 - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.

- *Centers for Medicare and Medicaid Services (CMS).*
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Plan*.

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *SPD*.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include dedicated speech-generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

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

Fertility Preservation for Iatrogenic Infertility

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

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

Benefits for medications related to the treatment of fertility preservation are provided as described under your *Outpatient Prescription Drug Plan* or under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available embryo transfer.

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

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.

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- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
 - Licensed speech-language pathologist.
 - Licensed audiologist.
 - Licensed occupational therapist.
 - Licensed physical therapist.
 - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, the Claims Administrator may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.

- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *SPD*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Infertility Services

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
 - One year, if you are a female under age 35.
 - Six months, if you are a female age 35 or older.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purpose of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

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

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - Outpatient

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Mental Health Care and Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

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

- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*) that are the following:
 - Focused on the treatment of core deficits of Autism Spectrum Disorder.
 - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
 - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

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

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Obesity - Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- You have a body mass index (BMI) of greater than 40.
- You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

Orthopedic Surgeries

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

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

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

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

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Plan*.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, the Claims Administrator may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

The Claims Administrator also has special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify the Claims Administrator regarding your Pregnancy.

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

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parent's chromosome (detectable by PGT-SR).

- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
 - Ovulation induction (or controlled ovarian stimulation).
 - Egg retrieval, fertilization and embryo culture.
 - Embryo biopsy.
 - Embryo transfer.
 - Cryo-preservation and short-term embryo storage (less than one year).

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

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.

- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- Vision therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

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- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy.
- Heart.
- Heart/lung.

- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

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

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits for urinary catheters you may require due to incontinence or retention.

Benefits are limited to indwelling and intermittent urinary catheters and do not include related supplies including:

- Incontinence garments or products (e.g. underwear, briefs, or diapers).
- Under pads (disposable or non-disposable).
- Gauze pads.
- Urinary drainage trays or insertion trays.
- Catheter care kits.
- Adhesive removers.
- Extension drainage tubing.
- Tubing sets.
- Drainage bags and bottles.
- Suspension supplies.
- Leg straps.
- External clamps.
- Urethral inserts.

- External catheters.
- External collection devices.
- Irrigation syringes.
- Bulbs or pistons.
- Lubricant.

Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Exams

Routine vision exams received from a health care provider in the provider's office for Covered Persons over the age of 19.

Wigs

Wigs and other scalp hair prosthesis regardless of the reason for hair loss.

Section 2: Exclusions and Limitations

How Are Headings Used in this Section?

To help you find exclusions, this section contains headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Wilderness, adventure, camping, outdoor, or other similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic injury, cancer or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

- Removal, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.

- Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
 5. Oral appliances for snoring.
 6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
 7. Powered and non-powered exoskeleton devices.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 1, *Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

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

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:
 - Abdominoplasty.
 - Blepharoplasty.
 - Body contouring, such as lipoplasty.

- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal, except as part of a genital reconstruction procedure by a physician for the treatment of gender Dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.
- Urinary catheters for which Benefits are provided as described under Urinary Catheters in *Section 1: Covered Health Care Services*.

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is a part of treatment.
 - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Saunas.
 - Stair lifts and stair glides.
 - Strollers.
 - Safety equipment.
 - Treadmills.
 - Vehicle modifications such as van lifts.
 - Video players.

- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Schlerotherapy treatment of veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke.
8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
15. Helicobacter pylori (H. pylori) serologic testing.
16. Intracellular micronutrient testing.
17. Health care services provided in the emergency department of a Hospital or Alternative Facility that are not for an Emergency.
18. Cellular and Gene Therapy services not received from a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
 - Has not been involved in your medical care prior to ordering the service, or
 - Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

Reproduction

1. The following Infertility treatment-related services:
 - This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services* in *Section 1: Covered Health Care Services*.
 - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
 - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
 - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
 - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
 - Ovulation predictor kits.
2. The following services related to Gestational Carrier or Surrogate:
 - Fees for the use of a Gestational Carrier or Surrogate.
 - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to a Gestational Carrier.
 - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. Voluntary sterilization.
5. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
6. Emergency contraceptives.
7. Fetal reduction surgery.
8. Maternity related medical services for Enrolled Dependent children or Enrolled Dependent children of Enrolled Dependent Children. This exclusion does not apply to prenatal services for which Benefits are provided under *the United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.
9. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility. This exclusion does not apply to InVitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services* in *Section 1: Covered Health Care Services*.
10. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
11. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
12. Infertility treatment following unsuccessful reversal of voluntary sterilization.
13. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Plan Sponsor's that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health care services for transplants involving permanent mechanical or animal organs.

Travel

1. Travel or transportation expenses, even though prescribed by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Care Services described below in Clinical Programs and Resources*. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services in Section 1: Covered Health Care Services*.

Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care in Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
3. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
4. Bone anchored hearing aids except when either of the following applies:
 - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
 - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Plan.

Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:
 - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.

6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Plan Sponsor. The Plan Sponsor will submit the completed forms to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

To enroll, call the Plan Sponsor or log onto web.com within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and the Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld. In most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of the Plan Sponsor's cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Plan Sponsor or logging onto web.com.

What If You Are Hospitalized When Your Coverage Begins?

The Plan will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Plan.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify the Claims Administrator of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

The Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as an Employee. For a complete definition of Eligible Person, Plan Sponsor and Employee, see *Section 9: Defined Terms*.

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

Dependent

Dependent generally refers to the Employee's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.

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

- Your Spouse.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.
- Your unmarried child age 26 but under age 30 who is:
 - A Full-time Student.
 - Not regularly employed on a full-time basis.
 - Primarily dependent on you for support and maintenance.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Plan Sponsor sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Employee's may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

Sample Company Medical and Outpatient Prescription Drugs Plan

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Employee's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be an Employee or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Employee," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the date the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- **Employees Retires or Is Pensioned**

The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the date the Employee is retired or receiving benefits under the Plan Sponsor's pension or retirement plan.

This provision applies unless there is specific coverage classification for retired or pensioned persons in the Plan, and only if the Employee continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Employee that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Employee for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, the Plan Sponsor may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan Sponsor's request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Plan ends will not end automatically. The Plan Sponsor will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Eighteen months from the date coverage would have ended when the entire Plan ends.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

Sample Company Medical and Outpatient Prescription Drugs Plan

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by the Claims Administrator. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

How Are Outpatient Prescription Drug Benefits Paid?

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Care Service, you may submit a pre-service request for Benefits as described in this section.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Employee's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.

- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

Payment of Benefits

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

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

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

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

Any such payment to a provider:

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

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments in Section 7: Coordination of Benefits*.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans’ recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Claims Administrator in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Claims Administrator will notify you of the decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

For medical claims, the appeals address is:

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

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

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review Program

You may be entitled to request an external review of the Plan Sponsor's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Plan Sponsor.
- The Plan Sponsor fails to respond to your appeal within the timeframe required by the applicable regulations.

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the Plan Sponsor at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Plan Sponsor's final appeal decision.

An external review request should include all of the following:

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

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

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

Standard External Review

A standard external review includes all of the following:

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

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

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

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims among the *IROs* or by using a random selection process.

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

The Claims Administrator will provide to the assigned *IRO* the documents and information considered in making the Plan Sponsor's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Plan Sponsor.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Plan Sponsor. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing the Plan Sponsor's determination, , the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review*

Decision agrees the Claims Administrator's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
 - The life or health of the individual.
 - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
 - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
 - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

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

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

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

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Plan Sponsor. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the *IRO's* final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

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

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

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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	15 days
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision

Pre-Service Request for Benefits*

Type of Request for Benefits or Appeal	Timing
The Plan Sponsor must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

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

Post-Service Claims

Type of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Plan Sponsor must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

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

Sample Company Medical and Outpatient Prescription Drugs Plan

- A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- C. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.

- (b) The Plan covering the Custodial Parent's spouse.
- (c) The Plan covering the non-Custodial Parent.
- (d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
 - d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable Expense.

- The Plan pays the entire difference between the Allowable Expense and the amount paid by the Primary Plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

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

Determining the Allowable Expense If this Plan is Secondary

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

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

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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

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

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits,

Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

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

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

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

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

Right to Receive and Release Needed Information?

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

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

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all treatments you or your Physician may believe are needed. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The relationships between the Claims Administrator and Network providers and Plan Sponsors are solely contractual relationships between independent contractors. Network providers and Plan Sponsors are not the Claims Administrator's agents or employees. Neither the Claims Administrator nor any of the Claims Administrator's employees are agents or employees of Network providers or the Plan Sponsor's.

Plan Sponsors and the Claims Administrator do not provide health care services or supplies, or practice medicine. Plan Sponsors and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not the Plan Sponsor's employees. Network providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator do not have any other relationship with Network providers such as principal-agent or joint venture. The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any provider.

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

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.

- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Plan Sponsors?

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

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Plan Sponsor is that of employer and employee, Dependent or other classification as defined in the Plan.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Employees and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Employees

All statements made by the Plan Sponsor or by an Employee shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.

- **Capitation** - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- **Bundled payments** - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The ap Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your Schedule of Benefits.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card if you have any questions.

Does the Claims Administrator Receive Rebates and Other Payments?

The Plan Sponsor and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. The Plan Sponsor and the Claims Administrator do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD*, the *Schedule of Benefits* and any *Summary Material Modifications (SMM)*, and/or Amendments.

- Make factual determinations related to the Plan and its Benefits.

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Sponsor may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that the Plan Sponsor does so in any particular case shall not in any way be deemed to require the Plan Sponsor to do so in other similar cases.

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

What is the Future of the Plan?

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

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or *Employee Retirement Income Security Act of 1974 (ERISA)*, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

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

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

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment or SMM. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan's next anniversary date, except as otherwise permitted by law.

- SMMs to the Plan are effective on the date the Plan Sponsor specifies.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Claims Administrator may use or disclose your information is found in the Claims Administrator's *Notice of Privacy Practices*.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. UnitedHealthcare agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to the Claims Administrator's *Notice of Privacy Practices*.

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

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

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan Sponsor's Plan is the secondary payer as described in *Section 7: Coordination of Benefits*, the Claims Administrator will process the Plan Sponsors payment of Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Sponsor's Plan is the secondary payer, the Claims Administrator will process the Plan Sponsor's payment of any Benefits available to you under the Plan as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

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

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

Subrogation Example:

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

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

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the

individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

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

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plans discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

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

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's

overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The *SPD*, the *Schedule of Benefits*, and any SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

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

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in 42 CFR 414.605.

Allowed Amounts - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator or as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings in accordance with one or more of the following methodologies:

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

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

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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

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

Annual Deductible - the total of the Allowed Amount, or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It

does not include any amount that exceeds Allowed Amounts or the Recognized Amount when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Plan.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

Coinsurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount, or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness and Substance-Related and Addictive Disorders, or their symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.

- Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:
 - "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
 - "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Provided to a Covered Person who meets the Plan's eligibility requirements.

Covered Person - the Employee or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Employee's legal spouse or a child of the Employee or the Employee's spouse. All references to the spouse of an Employee shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Employee or the Employee's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Plan Sponsor is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Employee.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age 26.

The Employee must reimburse the Plan for any Benefits paid during a time a child did not satisfy these conditions.

Designated Diagnostic Provider - a provider and/or facility that we have identified through our designation programs as a Designated Diagnostic Provider.

Designated Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that the Claims Administrator has identified as Designated Providers. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Domestic Partner - a person of the opposite or same sex with whom the Employee has a Domestic Partnership.

Domestic Partnership - a relationship between an Employee and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent.

The Employee and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.

- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and supporting documents.

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

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

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd or as would be required under such section if such section applied to an *Independent Freestanding Emergency Department*) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items or services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Employee - a full-time Employee of the Plan Sponsor who meets the eligibility requirements specified in the Plan. An Employee must live and/or work in the United States.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and Plan Sponsor make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- The Claims Administrator and Plan Sponsor may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition if:
 - If you are not a participant in a qualifying Clinical Trial as described under Section 1: Covered Health care Services; and
 - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

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

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Care Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate

skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

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

Intermittent Care - skilled nursing care that is provided either:

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

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

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medicaid - a federal program administered and operated individually by participating state and territorial governments. The program provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

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

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

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

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

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator's PDL Management Committee.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Sponsor sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription medications, products or devices administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

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

Plan - the Plan Sponsor's Self-Funded group health benefit plan.

The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-A - for aneuploidy (formerly PGS).
- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, placing Pharmaceutical Products into specific tiers.

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

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

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

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Recognized Amount - the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:.

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

- 1) An *All Payer Model Agreement* if adopted,
- 2) State law, or
- 3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The treatment plan will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

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

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Employee and each Enrolled Dependent, in accordance with the terms of the Plan.

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

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.

In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by the Claims Administrator. If this happens, you should call the telephone number shown on your ID card for assistance with resolving that issue. Shared Savings Program providers are not Network providers and are not credentialed by the Claims Administrator.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Products - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this *SPD*. Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

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

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

Total Disability or Totally Disabled - an Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Therapeutic Donor Insemination (TDI): Insemination with a donor sperm sample for the purpose of conceiving a child.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator and Plan Sponsor may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator and Plan Sponsor must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Amendment: Real Appeal

This Amendment to the Plan is issued by the Plan Sponsor as described below.

Because this Amendment is part of a legal document, the Plan wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Plan has defined these words in the *Summary Plan Description* in *Section 9: Defined Terms*.

What is the Real Appeal Amendment?

This Amendment to the Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact the Claims Administrator through www.realappeal.com, <https://member.realappeal.com> or at the number shown on your ID card.

Amendment: UnitedHealthcare Motion

This Amendment to the SPD provides a description of the UnitedHealthcare Motion wellness program.

Because this Amendment is part of a legal document (the Plan *SPD*), the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Plan has defined these words in the *Summary Plan Description* in *Section 9: Defined Terms*.

When the Plan Sponsor uses the words "you" and "your", the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

What is the UnitedHealthcare Motion Wellness Program Amendment?

The Plan Sponsor has implemented a wellness program that rewards you for completing certain wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the wellness program, then you might qualify for an opportunity to earn the same reward by different means. You may call the Claims Administrator toll-free at 1-855-256-8669. You can also call the Claims Administrator at the telephone number listed on your ID card, and the Claims Administrator will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

Walking Targets

You will receive a program activation credit. You will also receive a reward when you meet any of the walking targets listed below.

Walking Marker	Walking Target	Reward
Frequency	Six walks per day separated by at least one hour. A "walk" is defined as 500 steps in seven minutes	
Intensity	3,000 steps in any consecutive 30 minute time period	
Tenacity	10,000 steps during a 24 hour time period	

Rewards

Tracking Device

A tracking device approved by the Claims Administrator must be used to track steps towards earning a reward.

Amendment: Wellness

This Amendment to the Plan is issued by the Plan Sponsor as described below.

Because this Amendment is part of a legal document, the Plan wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Plan has defined these words in the *Summary Plan Description* in *Section 9: Defined Terms*.

What is the Wellness Amendment?

This Amendment describes the health and wellness tool that applies digital experiences, tools, games and rewards designed to engage Covered Persons in managing their health.

Who Is Eligible?

Participation is available to Covered Persons age 13 years and older; however, wellness rewards are only available to Covered Persons age 18 years and older.

What Are the Wellness Opportunities?

The health and wellness tool includes a wide range of wellness engagement opportunities. Engagement opportunities include the following:

- Interactive social media and games, which may include taking part in wellness challenges and health communities.
- *Health Survey*.
- *Online Personal Health Record*.
- An *Invite* to create personal missions.
- Integration with a variety of wellness devices (for example, wearable wireless trackers and mobile tools).

What Are the Rewards?

Covered Persons, age 18 years and older, receive wellness rewards for taking part in health and wellness opportunities as described above. When you take part in a health and wellness opportunity, you earn "coins" as a reward. For example, you may earn 40 coins for completing a *Health Survey*. You can save up coins and use the coins to enter into sweepstakes.

If you cannot meet a standard for a certain wellness reward, then you might qualify to earn the same reward by different means. You may call the Claims Administrator at the telephone number listed on your identification (ID) card who will work with you (and, if needed, with your doctor) to find another way for you to earn the same reward.

Clinical Programs and Resources

Care Management

Care Management Solutions

Personal Health Support

The Claims Administrator provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents who reside in the United States.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, the Claims Administrator may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, Personal Health Support Nurses will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

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

Medication Management

The Claims Administrator provides a service called the Medication Therapy Management Report especially for individuals who use multiple medications. This service looks to identify and prevent potential problems which can occur in individuals who use more than one medication. In order to help you make the most of your medications, a copy of this report is sent to your Physician for review.

Your specific Medication Therapy Management Report includes a list of medications dispensed for you under your pharmacy benefit plan within the past six months. Your Physician is asked to review this report:

- To identify potential drug interactions with the prescription medications that have been prescribed to you.
- To note if more than one medication is serving the same purpose.
- To determine if a needed medication is missing.

If your Physician identifies any concerns after reviewing the report, he or she may contact you if appropriate.

If you have any questions about any of the information presented in the Medication Therapy Management Report after you receive it please call the number provided on the report.

Complex Medical Conditions, Programs and Services

Bariatric Resource Services (BRS)

Your Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

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

Cancer Support Program

The Claims Administrator provides a program that identifies and supports a Covered Person who has cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and

advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on your ID card or call the program directly at 1-866-936-6002.

Congenital Heart Disease (CHD) Resource Services

The Claims Administrator provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on your ID card.

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

Family Support Plus

Family Support Plus provides navigation support and, if needed, clinical advice, to caregivers of children (age 0-17) with any behavioral health need(s). The family can engage directly with a Behavioral Health Coordinator (BHC, non-clinical), who gets to know the family and needs. Many times, behavioral health education, solution-focused recommendation and navigation can solve the family's needs. For higher level needs, the family is assigned to a dedicated 1:1 Behavioral Health Advocate (BHA, clinical) (masters prepared, licensed clinician) who provides tailored support to identify, address and help resolve gaps related to navigating the healthcare system, helps to find the right providers/specialists, helps with treatment options, and provides support to the caregiver/family with clear actionable steps, education, information and support.

The product is designed to help the family get to the right care at the right time, improve outcomes, build confidence in navigating the healthcare system, shorten time to treatment and improve member overall experience.

Kidney Disease Programs

Comprehensive Kidney Solution (CKS) program

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

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

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

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

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

Kidney Resource Services program (KRS) program

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

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

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

Orthopedic Health Support Program

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond.

This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre-surgical and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.
- Access to Designated Providers for certain inpatient and outpatient orthopedic surgeries for which Benefits are provided as described under *Orthopedic Surgeries* in *Section 1: Coverage Health Care Services*.

If you are considering surgery you must contact an orthopedic nurse prior to surgery to enroll in the program in order for the surgery to be considered a Covered Health Care Service under the Plan.

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

Transplant Resource Services (TRS) Program

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

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

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

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

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Care Services described below* is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Allowed Amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

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

Travel and Lodging Expenses

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

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below. The Allowed Amount for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of \$10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The orthopedic health support program provides a maximum of \$2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

Lodging Reimbursement Assistance

- A per diem rate, up to \$50.00 per day, for the Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to \$100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Decision Support

Decision Support

In order to help you make informed decisions about your health care, the Claims Administrator has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

Second Opinion Service

The Plan offers a second opinion service.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

NurseLineSM

NurseLineSM is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that Plan Sponsor has available that may help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLineSM gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no additional cost. To use this service, simply call the number on your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - Education about the specific disease and condition.
 - Medication management and compliance.
 - Reinforcement of on-line behavior modification program goals.
 - Preparation and support for upcoming Physician visits.
 - Review of psychosocial services and community resources.
 - Caregiver status and in-home safety.

- Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health. You can visit the site by going to www.myuhccom.

The program is provided through AbleTo, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Wellness Management/Preventive Care

Quit For Life Program

The Claims Administrator provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.

UnitedHealth Personal Rewards®

UnitedHealth Personal Rewards® (UPR) is annual program that provides rewards for completing applicable health actions. The program may include general health actions, such as completing a health survey, and/or a biometric screening; or, personalized health actions such as applicable preventive cancer screenings, and/or weight management. The health actions may also require meeting specific targets, such as Basic Metabolic Index (BMI). The program components, applicable rewards and eligibility are defined by the Plan Sponsor. The UPR program may change from year to year, depending upon what options the Plan Sponsor selects. If you are unable to meet a standard related to a health factor to obtain a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact the number on your ID card and the Claims Administrator will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward.

Getting Started:

At any time during the program year, go to www.myuhc.com to register and get started on the incentive program. Once you are registered, you can view your incentive program, completed health actions, earned rewards, including Rally® coins, and maximum annual incentive.

Tracking Your Progress:

To help you keep track of your progress, you can access your personal scorecard online and/or you may receive a scorecard in the mail. Once you have completed the health action(s), you will be eligible to receive your incentive. Please consult with the Plan Sponsor to see if your organization received mailed scorecards.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get educational information and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

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

Neonatal Resource Services

Neonatal Resource Services (NRS) is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

When you enroll in this program, the Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Provider's participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under the Covered Health Care Service Category.

Consumer Solutions and Self-Service Tools

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

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. The Claims Administrator and the Plan Sponsor are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

www.myuhc.com

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

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLineSM.

Sample Company Medical and Outpatient Prescription Drugs Plan

- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

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

Health Actions Portal - Diabetes Health Plan

This Plan includes access to an online portal available specifically for members enrolled in the Diabetes Health Plan for monitoring your progress toward meeting all the participation criteria described in the *Schedule of Benefits* and *Section 11: Outpatient Prescription Drugs* of this SPD required to maintain eligibility in the Plan. You're encouraged to visit the site frequently to keep abreast of the activities you should be completing to be eligible for enhanced benefits and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for diabetes self-care and prevention. You can visit the site by going to dhp.healthmine.com.

Health Survey

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

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

To find the health survey, log in to www.myuhc.com. logging in, access your personalized Health & Wellness page. If you need any assistance with the online survey, please call the number on your ID card.

SimplyEngaged Plus

SimplyEngaged Plus is a health and wellness program which allows you to earn rewards for completing certain requirements.

Note:

If you are unable to meet a standard related to a health factor to obtain a reward, you might qualify for an opportunity to earn the same reward by different means. Contact consumer support at 1-855-215-0230 and UnitedHealthcare will work with you (and, if necessary, with your doctor) to find another way for you to earn the same reward.

Here is how to start earning rewards.

Access the Reward Program Overview through Rally™ when you log in to www.myuhc.com for specific details regarding your wellness incentive program.

Call a Health Coach at 1-800-478-1057 to begin a telephone-based Health Coaching program.

Please call 1-855-215-0230 if you have questions about your rewards.

Outpatient Prescription Drug Plan Schedule of Benefits

United HealthCare Services, Inc.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. Supply limits are subject, from time to time, to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee. The reason for obtaining prior authorization from the Claims Administrator is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

The Plan may also require you to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee so the Claims Administrator can determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Claims Administrator's review and change. There may be certain Prescription Drug Products that require you to notify the Claims Administrator directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you can ask the Claims Administrator to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. The Claims Administrator's contracted pharmacy reimbursement rates (the Claims Administrator's Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from the Claims Administrator as described in this *Summary Plan Description (SPD)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and the Claims Administrator determines that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

The Claims Administrator may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Outpatient Prescription Drug Plan are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

You are responsible for paying the Annual Drug Deductible.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

Benefits for insulin or diabetic supplies are not subject to payment of the Annual Drug Deductible.

The Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Annual Drug Deductible.

The amount you pay for any of the following under this Outpatient Prescription Drug Plan will not be included in calculating any Out-of-Pocket Limit stated in this *SPD*:

- Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.
- Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Plan Benefit.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a plan year basis.

The Out-of-Pocket Drug Limits are calculated on a plan year basis.

The Infertility Annual Maximum Benefit is calculated on a plan year basis.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Prescription Drug Products at a Network or out-of-Network Pharmacy in a year before the Plan begins paying for Prescription Drug Products. Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible. Coupons: the Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	Network \$XX per Covered Person, not to exceed \$XX for all Covered Persons in a family.
Out-of-Pocket Drug Limit	
The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Limit, you will not be required to pay Copayments or Coinsurance for covered Prescription Drug Products for the remainder of the	Network \$XX per Covered Person, not to exceed \$XX for all Covered Persons in a family. The Out-of-Pocket Drug Limit includes the Annual Drug Deductible.

Payment Term And Description	Amounts
year. Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Limit. Coupons: the Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Drug Limit. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	
Infertility Annual Maximum Benefit	
The maximum amount the Outpatient Prescription Drug Plan will pay for covered Prescription Drug Products for Infertility during a year.	\$XX per Covered Person.
Infertility Maximum Policy Benefit	
The maximum amount the Outpatient Prescription Drug Plan will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Outpatient Prescription Drug Plan.	\$XX per Covered Person.
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. Coinsurance Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network

Payment Term And Description	Amounts
Prescription Drug Charge. Coinsurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. Copayment and Coinsurance Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. Special Programs: The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
Copayment/Coinsurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, the Claims Administrator may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. Prescription Drug Products Prescribed by a Specialist: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: the Claims Administrator may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	

Outpatient Prescription Drug Plan Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	Network Pharmacy For a Tier 1 Specialty Prescription Drug Product: \$XX per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: \$XX per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: \$XX per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: \$XX per Prescription Order or Refill.	The following supply limits apply. As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
Prescription Drugs from a Retail Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	Network Pharmacy For a Tier 1 Prescription Drug Product: \$XX per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: \$XX per Prescription Order or Refill. For a Tier 3 Prescription Drug Product \$XX per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: \$XX per Prescription Order or Refill.	
Prescription Drug Products from a Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	Network Mail Order Pharmacy For up to a 31-day supply, you pay: For a Tier 1 Prescription Drug Product: \$XX per Prescription Order or Refill For a Tier 2 Prescription Drug Product: \$XX per Prescription Order or Refill For a Tier 3 Prescription Drug Product: \$XX per Prescription Order or Refill For a Tier 4 Prescription Drug Product: \$XX per Prescription Order or Refill	Network Mail Order The following supply limits apply: As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products.

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
		Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. The Claims Administrator may allow a 31-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may find out whether a 31-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

Outpatient Prescription Drug Plan

United HealthCare Services, Inc.

This portion of the Plan provides Benefits for Prescription Drug Products.

Because this section is part of a legal document, the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Claims Administrator has defined these words in either the *Summary Plan Description (SPD)* in *Section 9: Defined Terms* or in this Plan in *Outpatient Prescription Drug Defined Terms*.

When the Plan Sponsor uses the words "you" and "your" the Plan Sponsor is referring to people who are Covered Persons, as the term is defined in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in this *SPD* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Outpatient Prescription Drug Plan. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *SPD*.

Introduction Outpatient Prescription Drug Plan

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

The Claims Administrator may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Plan as described in this *SPD* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager at the address on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

When Does the Claims Administrator Limit Selection of Pharmacies?

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will choose a Network Pharmacy for you.

Rebates and Other Payments

The Claims Administrator and Sample Company may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. As determined by the Claims Administrator, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayments and/or Coinsurance.

The Claims Administrator and a number of the Claims Administrator's affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Plan*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Plan*. The Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, the Claims Administrator may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, the Claims Administrator may direct you to the Mail Order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy but do not inform the Claims Administrator, you will be subject to the

out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Please see *Outpatient Prescription Drug Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Outpatient Prescription Drug Plan Exclusions

Exclusions from coverage listed in this *SPD* also apply to this Outpatient Prescription Drug Plan. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided under the medical Benefits portion of the Plan in this *SPD*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in this *SPD*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
13. Unit dose packaging or repackagers of Prescription Drug Products.
14. Medications used for cosmetic purposes.

15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products that are emergency contraceptives.
18. Certain Prescription Drug Products for tobacco cessation.
19. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 4.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.
20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Claims Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Certain Prescription Drug Products that have not been prescribed by a Specialist.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.
29. A Prescription Drug Product with either:
 - An approved biosimilar.

- A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Diagnostic kits and products including associated services.
31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
32. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Outpatient Prescription Drug Defined Terms

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product.
- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price for out-of-Network Pharmacies for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

Annual Drug Deductible - the amount you must pay for covered Prescription Drug Products in a year before the Claims Administrator begins processing Plan payments for Prescription Drug Products. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Annual Drug Deductible applies.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by the Claims Administrator.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by the Claims Administrator.

Infertility - not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

- One year, if you are a female under age 35.
- Six months, if you are a female age 35 or older.

In addition, in order to be eligible for Benefits, you must also:

- Be a female under age 44.
- Have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

Infertility Annual Maximum Benefit - the maximum amount the Plan will pay for covered Prescription Drug Products for Infertility during a year. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Infertility Annual Maximum Benefit applies.

Infertility Maximum Policy Benefit - the maximum amount the Plan will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Outpatient Prescription Drug Plan. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Infertility Maximum Plan Benefit applies.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to the Claims Administrator review and change from time to time.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator PDL Management Committee.
- December 31st of the following calendar year.

Out-of-Pocket Drug Limit - the maximum amount you pay for covered Prescription Drug Products every year. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Out-of-Pocket Drug Limit applies.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that the Claims Administrator identifies as a preferred pharmacy within the Network for Maintenance Medication.

Prescription Drug Charge - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to the Claims Administrator's review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is generally appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - glucose meters including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products may include drugs on

the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Federal Notice

Language Assistance Services

The Claims Administrator provides free language services to help you communicate with us. The Claims Administrator offers interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. The Claims Administrator is available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEBOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ព័ត៌មានបន្ថែម: ជំនួយភាសាខ្មែរ (Khmer) តាមការសុំអាចទទួលបានឥតគិតថ្លៃ ទូរស័ព្ទ ទៅលេខ 1-866-633-2446.

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Maidawat nga awagan iti 1-866-633-2446.

DII BAA'AKONINIZIN: Diné (Navajo) bizaad bee yánihi'go, saad bee áka'anida'awo'igíí, t'áá jiiik'eh, bee ná'ahóót'i'. T'áá shoodi kohji' 1-866-633-2446 hodülnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

The Claims Administrator¹ does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

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

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

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

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

For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "The Claims Administrator" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Summary Plan Description (SPD)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:
 - Ambulatory patient services; emergency services; hospitalization; laboratory services; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.
- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:
 - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000.
 - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000.
 - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.

Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

Sample Company Medical and Outpatient Prescription Drugs Plan

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the plan is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
 - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
 - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
 - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Retroactive rescission of coverage under the plan is permitted, with 30 days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
 - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or *UnitedHealthcare* for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call the Claims Administrator at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from the Claims Administrator will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call the Claims Administrator at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, the Claims Fiduciary will review its decision. The Claims Fiduciary will also send you its written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, the Claims Fiduciary will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call the Claims Administrator at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact the Claims Administrator at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for grandfathered and non-grandfathered large group Plans that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Care Services under the Plan must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	Timing
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, the Claims Administrator will send you written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

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

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

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

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of the Claims Administrator's decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

The Claims Administrator² is required by law to protect the privacy of your health information. The Claims Administrator is also required to send you this notice, which explains how the Claims Administrator may use information about you and when the Claims Administrator can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. The Claims Administrator is required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information the Claims Administrator maintains that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The Claims Administrator will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

The Claims Administrator has the right to change its privacy practices and the terms of this notice. If the Claims Administrator makes a material change to its privacy practices, the Claims Administrator will provide to you, in the Claims Administrator's next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. The Claims Administrator will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if the Claims Administrator maintains a website for your particular health plan, the Claims Administrator will post the revised notice on your health plan website, such as www.myuhc.com. The Claims Administrator reserves the right to make any revised or changed notice effective for information the Claims Administrator already has and for information that the Claims Administrator receives in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer the Claims Administrator's business and to provide products, services and information of importance to Plan enrollees. The Claims Administrator maintains physical, electronic and procedural security safeguards in the handling and maintenance of Plan enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How the Claims Administrator Uses or Discloses Information

The Claims Administrator must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

The Claims Administrator has the right to use and disclose health information for your treatment, to pay for your health care and to operate the Claims Administrator's business. For example, the Claims Administrator may use or disclose your health information:

- **For Payment** of service fees due the Claims Administrator, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, the Claims Administrator may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** The Claims Administrator may use or disclose health information to aid in your treatment or the coordination of your care. For example, the Claims Administrator may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** The Claims Administrator may use or disclose health information as necessary to operate and manage its business activities related to providing and managing your health care coverage. For example, the Claims Administrator might talk to your physician to suggest a disease management or wellness program that could help improve your health or the Claims Administrator may analyze data to determine how the Claims Administrator can improve its services. The Claims Administrator may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, the Claims Administrator may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, the Claims Administrator may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** The Claims Administrator may use or disclose your health information for underwriting purposes; however, the Claims Administrator will not use or disclose your genetic information for such purposes.
- **For Reminders.** The Claims Administrator may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

The Claims Administrator may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** The Claims Administrator may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** The Claims Administrator may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family

member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, the Claims Administrator will use its best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when the Claims Administrator may disclose health information to family members and others involved in a deceased individual's care. The Claims Administrator may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless the Claims Administrator is aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** The Claims Administrator may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** The Claims Administrator may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. The Claims Administrator may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** The Claims Administrator may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on the Claims Administrator's behalf or provide the Claims Administrator with services if the information is necessary for such functions or services. The Claims Administrator's business associates are required, under contract with the Claims Administrator, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in the Claims Administrator's contract as permitted by federal law.

- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 - 1. HIV/AIDS;
 - 2. Mental health;
 - 3. Genetic tests;
 - 4. Alcohol and drug abuse;
 - 5. Sexually transmitted diseases and reproductive health information; and
 - 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to the Claims Administrator, it is the Claims Administrator's intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, the Claims Administrator will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give the Claims Administrator authorization to release your health information, the Claims Administrator cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if the Claims Administrator has already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. The Claims Administrator may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while the Claims Administrator will try to honor your request and will permit requests consistent with the Claims Administrator's policies, the Claims Administrator is not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). The Claims Administrator will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, the Claims Administrator will accept your verbal request to receive confidential communications, however; the Claims Administrator may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information the Claims Administrator maintains about you such as claims and case or medical management records. If the Claims Administrator maintains your health information electronically, you will have the right to request that the Claims Administrator send a copy of your health information in an electronic format to you. You

can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, the Claims Administrator may deny your request to inspect and copy your health information. If the Claims Administrator denies your request, you may have the right to have the denial reviewed. The Claims Administrator may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information the Claims Administrator maintains about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If the Claims Administrator denies your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by the Claims Administrator during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require the Claims Administrator to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll- free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to the Claims Administrator at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Claims Administrator at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. The Claims Administrator will not take any action against you for filing a complaint.

²This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD

- Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

The Claims Administrator³ is committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with the Claims Administrator, the Claims Administrator may collect personal financial information about you from the following sources:

- Information the Claims Administrator receives from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with the Claims Administrator, the Claims Administrator's affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

The Claims Administrator does not disclose personal financial information about the Plan's enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of the Claims Administrator's general business practices, the Claims Administrator may, as permitted by law,

disclose any of the personal financial information that the Claims Administrator collects about you without your authorization, to the following types of institutions:

- To the Claims Administrator's corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for the Claims Administrator's everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for the Claims Administrator, including sending promotional communications on the Claims Administrator's behalf.

Confidentiality and Security

The Claims Administrator maintains physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

³For purposes of this Financial Information Privacy Notice, the "Claims Administrator" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connexions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides the Claims Administrator's privacy practices for Medical Information, describes how the Claims Administrator may use and disclose your health information under federal privacy rules. There are other laws that may limit the Claims Administrator's rights to use and disclose your health information beyond what the Claims Administrator is allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when the Claims Administrator can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information
The Claims Administrator is allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
The Claims Administrator is not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
The Claims Administrator is allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
The Claims Administrator is not allowed to use health information for certain purposes.	CA, IA
The Claims Administrator will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
The Claims Administrator must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Prescriptions	
The Claims Administrator is allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
The Claims Administrator is allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
The Claims Administrator is allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
The Claims Administrator is allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
The Claims Administrator is not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
The Claims Administrator is allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
The Claims Administrator is allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
The Claims Administrator will collect HIV/AIDS-related information only with your written consent.	OR

Sample Company Medical and Outpatient Prescription Drugs Plan

Mental Health	
The Claims Administrator is allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, ME, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
The Claims Administrator is allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NY, NM, RI, TN, TX, UT, WI

Administrative Statement

If the Plan is not subject to *ERISA*, the following information applies to you.

Claims Fiduciary: The Plan Administrator is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan. The Claims Fiduciary shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Fiduciary shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

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

The Plan Sponsor has selected a provider Network established by UnitedHealthcare Insurance Company

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343
952-936-1300

Person designated as Agent for Service of Legal Process: Sample Company

ASSUMPTIONS

Benefits Current as of January 1, 2023

Claims Fiduciary	Plan Sponsor
Care Model	Personal Health Support 3.0
Coordination of Benefits	Come Out Whole
Cost Management Program	Shared Savings Program Enhanced (SSPE) on INN Outlier Cost Management non-Emergent (OCM-NE) on OON Reimbursement
Bariatric Resource Services	Yes
Cancer Resource Services	Yes
Congenital Heart Disease Services	Yes
Kidney Resource Services	Yes
Reproductive Resource Services	Yes
Outpatient Prescription Drugs	Covered
Patient Protection and Affordable Care Act	Non-Grandfathered
Personal Rewards	Yes



UHC SB/KA Client Satisfaction 2025 – CLIENT SURVEY

Questionnaire

INTRODUCTION

Welcome to the 2025 Annual Customer Survey. Your feedback is vital in [INSURANCE NAME]'s efforts to meet your expectations, address your concerns, and earn your satisfaction. Thank you for your participation. We are using your answers, along with those of other people, to better understand your perspective on [INSURANCE NAME]'s benefits offered to your organization's employees and how we can improve [INSURANCE NAME] insurance plans. This survey is brought to you by Burke.

Please be as specific, detailed and candid in your responses as possible. The survey takes less than 10 minutes. Your participation in this research is voluntary. Please complete all of the questions appearing on each screen and always scroll down to make sure you have answered all of the questions provided. When you are ready to move on to the next page, click the "Next" button located at the bottom of the screen.

Do not use the Back or Forward arrows on your browser to move through the survey. Please do so using only the "Next" button at the bottom of your screen. Click on the "Next" button when you are ready to begin your survey.

SCREENER

QS0. Are you involved in selecting and/or administering a health benefits insurer(s) for COMPANY?

- 1 Yes
- 2 No

[If no] Please provide the contact information for the person selecting and/or administering your health benefits.

- 1 Email Address
- 2 Name
- 3 Company

QS1. Are you a broker or consultant?

- 1 Yes
- 2 No

[If yes] Please confirm your information below and if eligible, we will follow up in the next couple of weeks.

- Email Address
- 1 Name
 - 2 Company

LOYALTY

Now, we would like to ask you a few questions specifically about [INSURANCE NAME].

Q1. How likely are you to recommend [INSURANCE NAME] to a colleague?
(Select the rating scale point that best describes how you feel.)

Q2. Why did you give [INSURANCE NAME] a/an insert Q1 response? (Enter your response in the box below. Be as specific as possible.)

Q3. Overall, how satisfied are you with [INSURANCE NAME]?
(Select the rating scale point that best describes how you feel.)

- Q4. How likely are you to retain **[INSURANCE NAME]** as the health insurance company for your employees?

EMPLOYEE COVERAGE & PLAN PERCEPTIONS

Now, we are going to ask you to think about your employees' experience with **[INSURANCE NAME]**.

- Q4. Based upon what you know, overall, how satisfied are your employees with **[INSURANCE NAME]**? (Select the rating scale point that best describes how your employees feel.)
- EA1. To what extent do you agree or disagree with each of these statements as they apply to your employees and their overall experience with **[INSURANCE NAME]**? (For each statement below, select the rating scale point that best describes how you feel.)
- a) The feedback I receive from our employees regarding their **[INSURANCE NAME]** health insurance plan is positive
 - b) Our employees have a good understanding of their plan benefits
 - c) **[INSURANCE NAME]**'s customer service representatives resolve our employees' issues quickly
 - d) Our employees can easily get the treatments prescribed to them (e.g., tests, procedures, prescription drugs)
 - e) Our employees are satisfied with the mental healthcare coverage their plan offers
 - f) The prior authorization process is easy for our employees to understand
- EP2. How much do you agree or disagree with each of these statements as they apply to **[INSURANCE NAME]**? (For each statement below, select the rating scale point that best describes how you feel.)
- a) **[INSURANCE NAME]** plans provide a good choice of in-network doctors and hospitals
 - b) **[INSURANCE NAME]** helps me provide benefits that attract and retain the best employees
 - c) Our employees are receiving the level of coverage I expect from our plan
 - d) The level of coverage provided by the **[INSURANCE NAME]** health plan meets our employees' medical needs
 - e) **[INSURANCE NAME]** provides an integrated experience across all of our health benefit programs and services (e.g., medical, pharmacy, behavioral health, clinical, wellness, consumer engagement, vision, dental, financial solutions, retiree) **[SHOW IF KA ONLY (SEGMENT=2)]**

PLAN FLEXIBILITY & ADAPTATIONS

- PF1. To what extent do you agree or disagree with each of these statements as they apply to **[INSURANCE NAME]**? (For each statement below, select the rating scale point that best describes how you feel.)
- a) Proactively offers coverage solutions that reflect changes in the marketplace
 - b) Allows for modifications of plan benefits as needed to accommodate the specific nature of my business (e.g., buy up options) **[SHOW IF KA Only (SEGMENT=2)]**
 - c) Provides a variety of plan options to meet my business needs

EASE OF DOING BUSINESS

- EB1. To what extent do you agree or disagree with each of these statements as they apply to **[INSURANCE NAME]**? (For each statement below, select the rating scale point that best describes how you feel.)

- a) [INSURANCE NAME] has a simple billing process
- b) [INSURANCE NAME] makes it easy to add or remove employees to the plan
- c) My partnership with [INSURANCE NAME] allows me to focus more time on my business
- d) [INSURANCE NAME]'s process for onboarding new employees is effective
- e) Regularly communicates with me throughout the year
- f) [INSURANCE NAME] makes it easy for me to get answers to my questions

RELATIONSHIP WITH COMPANY

- Q6. To what extent do you agree or disagree with each of the following statements? (For each statement below, select the rating scale point that best describes how you feel.)
- a) [INSURANCE NAME] "has my back"
 - b) I am important to [INSURANCE NAME]
 - c) [INSURANCE NAME] is a company that I trust

COST

- C1. How would you rate [INSURANCE NAME] with regard to...? (For each aspect below, select the rating scale point that best describes how you feel.)
- a) The value you receive from [INSURANCE NAME]'s products and services
 - b) Helping you minimize health care costs
 - c) The administrative costs incurred by your business / organization to provide health insurance [ASO ONLY (Show if FUNDING=2)]
 - d) The premium costs incurred by your business / organization to provide health insurance

SALES/RENEWAL/ACCOUNT SERVICE

- Q7. How would you rate your organization's overall experience with [INSURANCE NAME] during the sales or renewal process? (Select the rating scale point that best describes how you feel.)
- Q8A. What step or steps can [INSURANCE NAME] make to improve the sales or renewal process? (Select all that apply.)
- a) Make fewer changes to rates/premiums from year to year
 - b) Make fewer changes to plan benefits from year to year
 - c) Provide plan details earlier in the renewal process [Show if dumTENURE=0 or >2 (Blank or 1+ years)]
 - d) Provide useful details and explanations about the plans offered
 - e) Communicate plan changes clearly at the time of renewal
 - f) Provide valuable recommendations based on employee plan usage [SHOW IF KA ONLY (SEGMENT=2)]
 - g) Respond quicker to my questions/requests
 - h) Improve website or digital tools
 - i) Improve access to human support
 - j) Improve the timing of plan materials and quotes
 - k) Simplify the plans and billing materials
 - l) Expand the variety of plan offerings
 - m) Other, please specify: [ANCHOR]
 - n) Don't know [MUTUALLY EXCLUSIVE] [ANCHOR]
- Q9. Who did you go through to purchase your current health plan?
- a) A broker

- b) A consultant
- c) [INSURANCE NAME] directly
- d) A private exchange
- e) A public SHOP exchange
- f) A third-party payroll administrator (TPA)
- g) A business or industry association/trade group
- h) Another source; please specify:

SR5. In which of the following ways does your broker or consultant support your business? (Select all that apply.)

- a) My broker or consultant supports our employees by directly addressing plan questions
- b) My broker or consultant supports our employees by mediating their claims issues
- c) My broker or consultant supports me by directly addressing plan questions

DIGITAL

D1A. Thinking about [INSURANCE NAME]'s digital tools, to what extent do you agree or disagree with each of the following statements? (For each statement below, select the rating scale point that best describes how you feel.)

- a) [INSURANCE NAME]'s website for business management (e.g., enrolling new employees, bill payment) is easy to use
- b) [INSURANCE NAME] develops digital solutions that make it easier for my/our employees to use their plans
- c) The information available on the website or app is up-to-date
- d) It is easy to find what I am looking for on the website or app

D1F. How important are [INSURANCE NAME]'s digital tools (websites/apps) for managing your company's health insurance plan?

D1G. How confident are you in your ability to use and navigate [INSURANCE NAME]'s digital tools (websites/apps) to manage your company's health insurance plan?

CLIENT COMMUNICATIONS

COM1. To what extent do you agree or disagree with each of these statements as they apply to your communications with [INSURANCE NAME]?

(For each statement below, select the rating scale point that best describes how you feel.)

- a) [dumSHOW] provides effective communications to me as an employer
- b) [dumSHOW] provides helpful communications for me to use with my employees to get the most out of their benefits
- c) [INSURANCE NAME] provides communications that help me understand benefits

ACCOUNT MANAGEMENT – FAMS AND SAES

F1. According to [INSURANCE NAME]'s records, the name of your Field Account Manager is <FAM>. Are you familiar enough with <FAM> to rate their performance?

- a) **Set if respondent can rate UHC identified FAM (F1=1): <INSURANCE NAME> Field Account Manager, <name from sample: FAM>**
- b) **Set if respondent can rate a different FAM (F1=2): <INSURANCE NAME> Field Account Manager Contact, <"other" name from F1=2>**

- F2. Overall, how satisfied are you with the support provided by <dumFAM_vwd>? (Select the rating scale point that best describes how you feel.)
- F3. How would you rate <dumFAM_vwd>'s performance on each of the following? (For each aspect below, select the rating scale point that best describes how you feel.)
- a) Coordinating and communicating with me effectively
 - b) Providing me with easily understandable information
 - c) Helping answer my employee's questions
 - d) Explaining changes in rates and plans
 - e) Educating me and my employees on plan benefit offerings through open enrollment
 - f) Providing meaningful data, reporting, and insights to support your company's strategy and decisions
- F4. According to [INSURANCE NAME]'s records, the name of your Strategic Account Executive is <SAE>. Are you familiar enough with <SAE> to rate their performance?
- a) Set if respondent can rate UHC identified SAE (F4=1): <INSURANCE NAME> Strategic Account Executive, <name from sample: SAE>
 - b) Set if respondent can rate a different SAE (F4=2): <INSURANCE NAME> Strategic Account Executive Contact, <"other" name from F4=2>
- F5. Overall, how satisfied are you with the support provided by <SAE NAME>? (Select the rating scale point that best describes how you feel.)
- F6. How would you rate <dumSAE_vwd>'s performance on each of the following? (For each aspect below, select the rating scale point that best describes how you feel.)
- a) Tailoring strategic solutions to meet my business needs and expectations
 - b) Coordinating and communicating with me effectively.

SMALL BUSINESS MODULE (2-99 ONLY)

- SB1. How would you rate [INSURANCE NAME] on each of the following? (For each aspect below, select the rating scale point that best describes how you feel.)
- a) [INSURANCE NAME] respects my time and bandwidth as a small business owner
 - b) Plan costs are affordable for my business

ISSUES

- P1. In the past 3 months, which, if any, of these problems did you experience with [INSURANCE NAME]? (Select all that apply.)
- 98 Not applicable - I didn't experience any problems in the past 3 months
- 1. Enrollment accuracy
 - 2. Billing
 - 5. Claims
 - 6. Other, please specify: [Anchor at bottom of list]
 - 8. Unable to contact my account management team
 - 9. Providers who were previously in-network are now out-of-network.
 - 10. Referral issues
 - 11. Prior authorization issues
 - 12. Changes to prescription coverage
 - 13. Difficulty finding information regarding prescription benefits
 - 14. Customer support issues

15. Client portal issues
16. Employee website/portal issues (not app related)
18. Employee mobile app issues

SUREST SLICE SECTION (SUREST SLICE CLIENTS ONLY)

Now, please think about you and your employees' experience with **Surest**.

SS1. How likely are you to recommend **Surest** to a colleague? (Select the rating scale point that best describes how you feel.)

SS2. Why did you give **Surest** a/an **insert SS1 response**? (Enter your response in the box below. Be as specific as possible.)

SS3. Thinking about **Surest's** digital tools, to what extent do you agree or disagree with each of the following statements? (For each statement below, select the rating scale point that best describes how you feel.)

- a) **Surest** develops digital solutions that make it easier for my/our employees to use their plans
- b) Information provided on digital tools like website or app is up-to-date
- c) It is easy to find what I am looking for on the website or app

SS7. To what extent do you agree or disagree that your employees have a good understanding of their plan benefits? (Select the rating scale point that best describes how you feel.)

SS8. How would you rate **Surest** performance on the level of coverage provided by the **Surest** health plan relative to your employees' (and their families') medical needs? (Select the rating scale point that best describes how you feel.)

SS9. How would you rate **Surest** regarding the value you receive from **Surest** products and services? (Select the rating scale point that best describes how you feel.)

SS10. How would you rate the communications sent to you to use with your employees (open enrollment support, online tools for employers)? (Select the rating scale point that best describes how you feel.)

OPTUM RX

RX1. Now, thinking about the pharmacy benefit management solutions you receive from OptumRx. How likely are you to recommend OptumRx to a colleague? (Select the rating scale point that best describes how you feel.)

COMPANY PROFILE

- D6. In order to meet your expectations, address your concerns, and earn your satisfaction, it would be extremely helpful if we could follow up with you directly on the information you have provided. Do we have your permission to contact you regarding your feedback?
1. Yes, I am open to follow up
 2. No, please don't contact me

Please provide your preferred phone number for follow-up (enter 10 digits without dashes).

VIDEO OPEN END (QUOTA OF 100)

OE1. Are you currently using a device you are able to record a video response from (i.e., with a webcam and microphone, or on a device with a front facing camera)?

1. Yes
2. No - **Skip to NOT VIDEO if “No”**

OE2. **Ask if Yes at OE1**

For the next question, we would like you to video record your response. We find that we are able to get richer feedback when participants speak their thoughts out loud, rather than typing them into a text box. Your video responses will be held in a secure environment for an indefinite time period and disclosed to only those who have a need to know for research purposes. You will need to use a compatible browser such as Chrome, Mozilla, Safari or Microsoft Edge to participate. We are interested in your open and honest feedback. Your video responses will be used internally and may be shared with other audiences. Remember, there are no right or wrong answers. Just answer the way you feel best and have fun! Would you like to proceed?

1. I agree to share a video
2. I do not agree to share a video - **Skip to NOT VIDEO if “I do not agree”**

Ask if Yes at OE2 OE3. Please read the following consent regarding the video you will record. Please indicate whether you accept or do not accept these terms. Please note that your response will not affect your completion of this survey.

RELEASE & CONSENT

By clicking “I ACCEPT” I agree to be interviewed and recorded... [Continues with full legal release]

1. I accept
2. I do not accept - **Skip to NOT VIDEO if “I do not accept”**

Show if “I accept” at OE3 OE3. Please confirm your acceptance by entering your full name and state of residence:

Full Name: _____

State of Residence: _____

Checkbox Selection Option “I changed my mind and would like to opt out”

Show if “I accept” at OE3 OE4. Thank you for agreeing to record a video! Here are a few quick tips to keep in mind:

- You do **not** need to download anything, but you will need to use the camera and microphone on your device to record your video. Please ensure your camera and microphone are both switched on and working properly.
- Provide as much detail as you can; you have up to two minutes to talk, so use it!
- Make sure you have plenty of light so that we can clearly see you.
- Avoid places with lots of background noises so that we can clearly hear you.
- **Speak loud and clear** – we want to hear everything you have to say!
- **After you upload your video, please wait until you see the ‘Successfully Uploaded’ message to move on to the next question.**
- Relax and have fun!

This is what your video should look like.



Please select "Next" to continue.

Each respondent will only be asked 1 video open end.

OE7. What changes have you noticed at **[INSERT INSURANCE NAME]** in the past 12 months, and how have they affected your experience or work environment? Please be as specific as possible and include examples if you can. Please record a video response, providing as much detail as you can. Once you click to stop recording, please select "Accept Recording" and wait for your video to upload. Once uploaded successfully, select the Next button to finish the survey.

OE8. Tell us about a time when **[INSERT INSURANCE NAME]** exceeded—or fell short of—your expectations. What happened? Please be as specific as possible and include examples if you can. Please record a video response, providing as much detail as you can. Once you click to stop recording, please select "Accept Recording" and wait for your video to upload. Once uploaded successfully, select the Next button to finish the survey.

Checkbox Selection Option "I am having technical difficulties, or I would no longer like to record a video." *If respondent selects Technical Difficulties, capture open-end response as text. If respondent did not accept video, route them here:*

NOT VIDEO: Each respondent who declined to be on video will only be asked 1 open end.

OE7_NOTVIDEO. What changes have you noticed at **[INSERT INSURANCE NAME]** in the past 12 months, and how have they affected your experience or work environment? Please be as specific as possible and include examples if you can.

OE8_NOTVIDEO. Tell us about a time when **[INSERT INSURANCE NAME]** exceeded—or fell short of—your expectations. What happened? Please be as specific as possible and include examples if you can.

CLOSING

Those are all the questions that we have for you today. Thank you for your participation.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

04/29/2025

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

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

PRODUCER MARSH USA LLC 333 South 7th Street, Suite 1400 Minneapolis, MN 55402-2400 Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307 CN101631729-ALL*-GAWUP-25-26	CONTACT NAME: Enterprise Risk Financing & Insurance PHONE (A/C, No, Ext): E-MAIL ADDRESS: eis@uhg.com FAX (A/C, No): 888-299-6422
INSURED UNITEDHEALTH GROUP INCORPORATED 1 HEALTH DRIVE EDEN PRAIRIE, MN 55344	INSURER(S) AFFORDING COVERAGE INSURER A: Old Republic Insurance Company INSURER B: XL Specialty Insurance Company INSURER C: Travelers Property Casualty Company of America INSURER D: INSURER E: INSURER F:
	NAIC # 24147 37885 25674

COVERAGES**CERTIFICATE NUMBER:**

CHI-010928544-01

REVISION NUMBER: 1

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☒ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:			MWZY315405-26	05/01/2024	05/01/2026	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ 2,500 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000
A	☒ AUTOMOBILE LIABILITY ☒ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY			MWTB319191-25	05/01/2025	05/01/2026	COMBINED SINGLE LIMIT (Ea accident) \$ 10,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
B	☒ UMBRELLA LIAB ☒ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☐ RETENTION \$			US00075258LI25A	05/01/2025	05/01/2026	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ 10,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N ☒ N	N / A	UB-6R864629-25-NC-T (AOS) UB-6R80648A-25-NC-R (MA & WI) HWXJUB-472M4779-TIL-25 (XWC OH) (SIR \$2M - XWC OH)	05/01/2025 05/01/2025 05/01/2025	05/01/2026 05/01/2026 05/01/2026	☒ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000
A	Managed Care Prof. Liab / E&O Retro Date: 1/1/77			MWZZ315406-26	05/01/2024	05/01/2026	Each Claim \$ 10,000,000 Annual Aggregate \$ 10,000,000

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

EVIDENCE OF INSURANCE

CERTIFICATE HOLDER**CANCELLATION**UNITEDHEALTH GROUP INCORPORATED
1 HEALTH DRIVE
EDEN PRAIRIE, MN 55344

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

AUTHORIZED REPRESENTATIVE

Marsh USA LLC

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The Accessibility Center of Excellence

The Accessibility Center of Excellence (COE) works to ensure digital properties across the enterprise are accessible. The Accessibility COE includes people with disabilities. These are the elements of the Program:

Governance. Digital properties included in the Accessibility COE's scope go through an intake process. The Accessibility COE provides guidance for teams for long-term strategy for incorporating accessibility into their work. The Accessibility COE strives to complete at least one manual accessibility assessment per year for each digital property.

Communication. The Accessibility COE includes external and internal communication initiatives such as accessibility industry participation, a video featuring a member with disabilities and presentations at company-wide and departmental events to build awareness of people with disabilities and the Accessibility COE.

Accessibility Standards and Procedures. The Accessibility COE uses the accessibility standards outlined within Section 1557 of the Affordable Care Act and Section 508 of the Rehabilitation Act (WCAG 2.0 AA). In addition, the Accessibility COE is updating many digital properties and training materials to WCAG 2.2 AA. The Accessibility COE provides a detailed accessibility knowledge base to support accessibility work. The Accessibility COE has and continues to incorporate accessibility standards into other internal guidelines such as brand guidelines and design systems.

Accessibility Integration. The Accessibility COE's goal is to monitor and support accessibility integration and testing efforts. The Program's accessibility integration teams continuously support large, complex, high traffic digital properties. These teams provide a mix of on-the-job targeted training, coaching and support for the end-to-end development cycle including design reviews, user story writing, development, QA and UAT testing, launch and defect prioritization.

Documents. The Accessibility COE's The Document Team makes PDF documents accessible and follows PDF/UA Standards. The Document Accessibility Team uses both dynamic document creation and manual processes to make UHC documents accessible. The Document Team has an average turnaround time of 24 hours for member requests.

Vendors and Third-Party Technology. Accessibility due diligence reviews and assessments are performed on an as-needed basis.

Training. The Accessibility COE provides training to build general awareness, role-based webinar training for key business and technical roles and accessibility change management training.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2024

or

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of
incorporation or organization)

41-1321939
(I.R.S. Employer
Identification No.)

1 Health Drive
Eden Prairie, Minnesota 55344
(Address of principal executive offices) (Zip Code)

655 New York Avenue NW
Washington, DC 20001
(Address of principal executive offices) (Zip Code)

(800) 328-5979
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, \$.01 par value	UNH	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐	Non-accelerated filer	☐
Smaller reporting company	☐			Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐
Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒
If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐
Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒
The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2024 was \$468,433,146,650 (based on the last reported sale price of \$509.26 per share on June 30, 2024 as reported on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.
As of January 31, 2025, there were 914,712,333 shares of the registrant's Common Stock, \$.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2025 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

OUR BUSINESSES

Overview

The terms “we,” “our,” “us,” “its,” “UnitedHealth Group,” or the “Company” used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

UnitedHealth Group Incorporated is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two distinct, yet complementary businesses — Optum and UnitedHealthcare — are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve.

The ability to analyze complex data and apply deep health care expertise and insights allows us to serve patients, consumers, care providers, businesses, communities and governments with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

Optum seeks to create a higher-performing, value-oriented and more connected approach to health care. Bringing together clinical expertise, technology and data to make care simpler, more effective and more affordable, we seek to advance whole-person health, creating a seamless consumer experience and supporting clinicians with insights to deliver personalized, evidence-based care. Optum serves the broad health care marketplace, including patients and consumers, payers, care providers, employers, governments and life sciences companies, through its Optum Health, Optum Insight and Optum Rx businesses. These businesses improve overall health system performance by optimizing health care quality and delivery, reducing costs and improving patient, consumer and provider experience, leveraging distinctive capabilities in data and analytics, pharmacy care services, health care operations, population health and health financial services.

UnitedHealthcare offers a full range of health benefits, designed to simplify the health care experience and make it more affordable for consumers to access high-quality care. UnitedHealthcare Employer & Individual serves consumers and employers, ranging from sole proprietorships to large, multi-site and national employers and public sector employers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits to seniors and other Medicare eligible consumers. UnitedHealthcare Community & State serves consumers who are economically disadvantaged, the medically underserved and those without the benefit of employer sponsored health benefits coverage.

We have four reportable segments:

- Optum Health;
- Optum Insight;
- Optum Rx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State.

Optum

Optum is an information and technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: patients who need the right care, information, resources, products and engagement to improve their health, achieve their health goals and receive an improved patient experience that is personalized, comprehensive and delivered in all care settings, including in-home and virtually.
- Those who provide care: physicians, hospitals, pharmacies and others seeking to improve the health system and reduce the administrative burden, allowing for providers to focus time on patients leading to the best possible patient care and experiences while achieving better health outcomes at lower costs. Improved health outcomes are achieved by utilizing our clinical expertise, data and analytics to better understand, treat and prevent consumers’ health conditions and ensure they receive the best evidence-based care.
- Those who pay for care: consumers; employers; health plans; and state, federal and municipal agencies devoted to ensuring the people they sponsor receive high-quality care, administered and delivered efficiently and effectively, all while driving health equity so that every individual, family and community has access to the care they need.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines to improve care delivery and health outcomes.

Optum operates three business segments which combine distinctive capabilities in value-based care, population health, health care operations, data and analytics and pharmacy care services:

- Optum Health delivers patient-centered care, care management, wellness and consumer engagement, and health financial services;
- Optum Insight offers data, analytics, research, consulting, technology and managed services solutions; and
- Optum Rx provides diversified pharmacy care services.

Optum Health

Optum Health provides comprehensive and patient-centered care, addressing the physical, mental, social, and financial well-being of 100 million consumers and serves more than 100 health payer partners. We engage people in the most appropriate care settings, including clinical sites, in-home and virtual. Optum Health delivers primary, specialty and surgical care; helps patients and providers navigate and address complex, chronic and behavioral health needs; offers post-acute care planning services; and serves consumers and care providers through advanced, on-demand digital health technologies, such as telehealth and remote patient monitoring, and innovative health care financial services. Optum Health works directly with patients, consumers, care delivery systems, providers, employers, payers, and public-sector entities to provide high quality, accessible and equitable care with improved health outcomes and reduced total cost of care. Optum Health enables care providers to transition from traditional fee-for-service payment models to performance-based delivery and payment models designed to improve patient health outcomes and experience through value-based care.

Optum Health offerings include fully accountable value-based arrangements, where Optum Health assumes responsibility for health care costs in exchange for a monthly premium. Offerings also include administrative fee arrangements, where Optum Health manages or administers products and services in exchange for a monthly fee, and fee-for-service arrangements, where Optum Health delivers health-related products and medical services for patients at a contracted fee.

Optum Financial, including Optum Bank, serves consumers through more than 27 million consumer accounts with \$24 billion in assets under management as of December 31, 2024. Organizations across the health system rely on Optum Financial to manage and improve payment flows through its highly automated, scalable, end-to-end digital payment and financing systems and integrated card solutions. For financial services offerings, Optum Financial charges fees and earns investment income on managed funds.

Optum Health sells its products primarily through its direct sales force, strategic collaborations and external producers in three key areas: employers, including large, mid-sized and small employers; payers including health plans, third-party administrators (TPAs), underwriter/stop-loss carriers and individual product intermediaries; and public entities, including the U.S. Departments of Health and Human Services (HHS), Veterans Affairs, Defense, and other federal, state and local health care agencies.

Optum Insight

Optum Insight connects the health care system with services, analytics and platforms that make clinical, administrative and financial processes simpler and more efficient for all participants in the health care system. Hospital systems, physicians, health plans, public entities, life sciences companies and other organizations comprising the health care industry depend on Optum Insight to help them improve performance and reduce costs through administrative efficiency and payment simplification, advance care quality through evidence-based standards built directly into clinical workflows, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Health Systems. Serves hospitals, physicians and other care providers to improve operating performance, better coordinate care and reduce administrative costs through technology and services to improve population health management, patient engagement, revenue cycle management and strategic growth plans.

Health Plans. Serves health plans by improving financial performance and enhancing outcomes through proactive analytics, a comprehensive payment integrity portfolio and technology-enabled and staff-supported risk and quality services. Optum Insight helps health plans navigate a dynamic environment defined by shifts in employer vs. public-sector coverage, the demand for affordable benefit plans and the need to leverage new technology to reduce complexity.

State Governments. Provides advanced technology and analytics services to modernize the administration of critical safety net programs, such as Medicaid, while improving cost predictability.

Life Sciences Companies. Combines data and analytics expertise with comprehensive technologies and health care knowledge to help life sciences companies, including those in pharmaceuticals and medical technology, adopt a more comprehensive approach to advancing therapeutic discoveries and improving clinical outcomes.

Many of Optum Insight's software and information products and professional services are delivered over extended periods, often several years. Optum Insight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with Optum Insight's customers. Optum Insight's aggregate backlog as of December 31, 2024 was approximately \$32.8 billion, of which \$19.8 billion is expected to be realized within the next 12 months. The aggregate backlog includes \$12.5 billion related to affiliated agreements. Optum Insight's aggregate backlog as of December 31, 2023, was \$32.1 billion, including \$11.9 billion related to affiliated agreements.

Optum Insight's products and services are sold primarily through a direct sales force. Optum Insight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface Optum Insight's products with their applications.

Optum Rx

Optum Rx provides a full spectrum of pharmacy care services through its network of more than 65,000 retail pharmacies, through home delivery, specialty and community health pharmacies, the provision of in-home and community-based infusion services and through rare disease and gene therapy support services. It also offers direct-to-consumer solutions.

Optum Rx manages a broad range of prescription drug spend, including widely available retail drugs as well as limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology. Optum Rx serves the growing pharmacy needs of people with behavioral health and substance use disorders. In 2024, Optum Rx managed \$178 billion in pharmaceutical spending, including \$74 billion in specialty pharmaceutical spending.

Optum Rx serves health benefits providers, large national employer plans, unions and trusts, purchasing coalitions and public-sector entities. Optum Rx sells its services through direct sales, health insurance brokers and other health care consultants.

Optum Rx offers multiple clinical programs, digital tools and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner which are designed to deliver improved consumer experiences, better health outcomes and a lower total cost of care. Optum Rx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement each client's plan design and clinical strategies. Optum Rx is accelerating the integration of medical, pharmacy and behavioral care and treating the whole patient by embedding our pharmacists as key members of the patient care team.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, creating a better health care experience for its customers and helping to control rising health care costs. UnitedHealthcare's market position is built on:

- strong local-market relationships;
- the breadth of product offerings, based upon extensive expertise in distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement; and
- innovation for customers and consumers.

UnitedHealthcare arranges for discounted access to care through its extensive networks and uses Optum's capabilities to help coordinate and provide patient care, improve affordability of medical care, analyze cost trends, manage pharmacy care services, work with care providers more effectively and create a simpler and more satisfying consumer and physician experience.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

Domestically, UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, and individuals. As of December 31, 2024, UnitedHealthcare Employer & Individual provides access to medical services for 29.7 million people.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium which is typically a fixed rate per individual served for a one-year period. Through its administrative and other management services arrangements to customers who elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed

monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision professionals. UnitedHealthcare Employer & Individual is focused on providing informed benefit solutions that create customized plan designs and clinical programs for employers that contribute to well-being and reduce the total cost of care along with providing simpler consumer experiences in response to market dynamics.

UnitedHealthcare Employer & Individual typically distributes its products through a variety of channels, dependent upon the specific product, including: through consultants or direct sales, in collaboration with brokers and agents, through wholesale agents or agencies who contract with health insurance carriers to distribute individual or group benefits, through professional employer organizations and associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's major product families include consumer engagement products, such as high-deductible consumer driven benefit plans and a variety of innovative consumer centric products; traditional products; clinical and pharmacy products; and specialty benefits, such as vision, dental, accident protection, critical illness, disability and hospital indemnity offerings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to seniors and other Medicare eligible consumers, addressing their unique needs. UnitedHealthcare Medicare & Retirement has distinct benefit designs, pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products allowing people choice in obtaining the health coverage and services they need as their circumstances change. These offerings include care management and health system navigator services, clinical management programs, nurse health line services, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, a membership organization, and state and U.S. government agencies. Products are also offered through agents, employer groups and digital channels.

Major product categories include:

Medicare Advantage. Provides health care coverage for seniors and other eligible Medicare beneficiaries through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, Preferred Provider Organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health benefits coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement served 7.8 million people through its Medicare Advantage products as of December 31, 2024.

We have continued to enhance our offerings, focusing on more digital and physical care resources in the home, expanding our concierge navigation services and enabling the home as a safe and effective setting for care. For example, through our HouseCalls program, nurse practitioners performed 2.9 million clinical preventive home care visits in 2024 to address unmet care opportunities and close gaps in care.

Medicare Part D. Provides Medicare Part D benefits to beneficiaries through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. As of December 31, 2024, UnitedHealthcare enrolled 10.1 million people in the Medicare Part D programs, including 3.1 million individuals in stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. Provides a full range of supplemental products at diverse price points. These products cover various levels of coinsurance and deductible gaps to which seniors are exposed in the traditional Medicare program. UnitedHealthcare Medicare & Retirement served 4.3 million seniors nationwide through various Medicare Supplement products as of December 31, 2024.

Premium revenues from CMS represented 40% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2024, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families; Children's Health Insurance Programs (CHIP); Dual SNPs (DSNPs); Long-Term Services and Supports (LTSS); Aged, Blind and Disabled; and other federal, state and community health care programs. As of December 31, 2024, UnitedHealthcare Community & State participated in programs in 33 states and the District of Columbia, and served more than 7.4 million people; including 1.2 million people through Medicaid expansion programs in 20 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in medically underserved areas and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive U.S. federal and state and international laws and regulations. We are regulated by agencies which generally have discretion to issue regulations and interpret and enforce laws and rules. U.S. federal and state and international governments continue to consider and enact various legislative and regulatory proposals which could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political environment, could adversely affect our businesses.

See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with U.S. federal and state and international laws and regulations.

U.S. Federal Laws and Regulation

When we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts, which are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance, and the regulatory environment with respect to these programs is complex.

Our businesses are also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriate reduction or limitation of health care services, anti-money laundering and securities and antitrust compliance.

Privacy, Security and Data Standards Regulation. Certain of our operations are subject to regulation under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), which apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

Our businesses must comply with the Health Information Technology for Economic and Clinical Health Act (HITECH), which regulates matters relating to privacy, security and data standards. HITECH imposes requirements on uses and disclosures of health information; includes contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds federal data breach notification requirements for covered entities and business associates and reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The use and disclosure of individually identifiable health data by our businesses are also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations, which may apply to us, as discussed below. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those who maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations, which require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by the state’s regulation.

Our health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain affiliated transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material affiliated transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. Health care-related laws and regulations set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies which oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our beneficiaries dually eligible for Medicare and Medicaid. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations which may affect our privacy and security practices, such as state laws governing the use, disclosure and protection of social security numbers and protected health information or which are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws prohibiting specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices, which involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

Optum Rx's businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies which must be licensed as pharmacies in the states in which they are located. Certain of our pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our pharmacies to follow the laws of the state in which the pharmacies are located, but some non-resident states also require us to comply with their laws where pharmaceuticals are delivered. Additionally, certain of our pharmacies which participate in programs for Medicare and state Medicaid providers are required to comply with applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation regulating PBM activities affects both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) use of particular care providers or distribution channels, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. In addition, organizations like the NAIC periodically issue model regulations while credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards impacting PBM pharmacy activities. Although these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to online communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, the Federal Communications Commission (FCC) and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation (FDIC), which performs annual examinations to ensure the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

Non-U.S. Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating outside the United States, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services. Our competitors include organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants to our markets and business combinations among our competitors and suppliers also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; and sales, marketing and pricing. See Part I, Item 1A, “Risk Factors” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, Optum and UnitedHealthcare names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

HUMAN CAPITAL RESOURCES

Our nearly 400,000 employees, as of December 31, 2024, including more than 140,000 clinical professionals, are guided by our mission to help people live healthier lives and help make the health system work better for everyone. Our mission and cultural values of integrity, compassion, inclusion, relationships, innovation, performance and quality align with our long-term business strategy to increase access to care, make care more affordable, enhance the care experience, improve health outcomes and advance health equity. Our mission and values attract individuals who are determined to make a difference – individuals whose talent, innovation, engagement and empowerment are critical in our ability to achieve our mission.

We are committed to developing our people and culture by creating an inclusive environment where people of diverse talents, backgrounds, experiences and perspectives make us better. Our approach is data-driven and leader-led and uses enterprise and business scorecards to ensure our leaders are accountable for a consistent focus on hiring, developing, advancing and retaining diverse talent. We have embedded inclusion and diversity throughout our culture, including in our talent acquisition and talent management practices; leadership development; careers; learning and skills; and systems and processes. We strive to maintain a skilled, sustainable and diverse talent pipeline by building strong strategic partnerships and outreach through early career programs, internships and apprenticeships. We support career coaching, mentorship and accelerated leadership development programs to ensure mobility and advancement for our diverse talent. To foster an engaged workforce and an inclusive culture, we invest in a broad array of skills-based learning and culture development programs. We rely on a shared leadership framework, which clearly and objectively defines our expectations, enables an environment where everyone has the opportunity to learn and grow, and helps us identify, develop and deploy talent to help achieve our mission.

We prioritize pay equity by objectively and regularly evaluating and reviewing our compensation practices by performance, age, experience, gender, ethnicity and race. Receiving on-going feedback from our team members is another way to strengthen and reinforce a culture of inclusion. Our Employee Experience Index measures an employee’s sense of commitment and belonging to our company and is a metric in the Stewardship section of our annual incentive plan. Our Sustainability Report, which can be accessed on our website at www.unitedhealthgroup.com, provides further information about our people and culture.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of February 27, 2025, including the business experience of each executive officer during the past five years:

Name	Age	Position
Andrew Witty	60	Chief Executive Officer
John Rex	63	President and Chief Financial Officer
Heather Cianfrocco	51	Chief Executive Officer, Optum
Erin McSweeney	60	Executive Vice President and Chief People Officer
Timothy Noel	53	Chief Executive Officer, UnitedHealthcare
Thomas Roos	52	Senior Vice President and Chief Accounting Officer
Christopher Zaetta	53	Executive Vice President and Chief Legal Officer and Corporate Secretary

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Andrew Witty has served as Chief Executive Officer and a member of the Board of Directors of UnitedHealth Group since February 2021. Previously, Andrew served as Chief Executive Officer of Optum from July 2018 to April 2021, President of UnitedHealth Group from November 2019 to February 2021 and as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, he was Chief Executive Officer and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to 2017.

John Rex has served as President and Chief Financial Officer of UnitedHealth Group since April 2024. Previously, John served as Chief Financial Officer of UnitedHealth Group since June 2016. From March 2012 to June 2016, he served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, John was a Managing Director at JP Morgan, a global financial services firm.

Heather Cianfrocco has served as Chief Executive Officer of Optum since April 2024. Previously, Heather served as Optum's President and held numerous leadership roles since joining UnitedHealth Group from 2008 until April 2024, including serving as Chief Executive Officer of Optum Rx, Chief Executive Officer for Optum's Health Services and Chief Executive Officer of UnitedHealthcare Community & State.

Erin McSweeney has served as Executive Vice President and Chief People Officer of UnitedHealth Group since March 2022. From February 2021 to March 2022, Erin served as chief of staff to UnitedHealth Group's Office of the Chief Executive. From January 2017 to February 2021, she served as Executive Vice President and Chief Human Resources Officer at Optum. Prior to joining UnitedHealth Group, Erin was Executive Vice President and Chief Human Resources Officer for EMC Corporation, an international technology company.

Tim Noel has served as Chief Executive Officer of UnitedHealthcare since January 2025. Previously, Tim served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement business and held numerous leadership roles since joining UnitedHealth Group from 2007 until January 2025, including serving as Chief Financial Officer and Senior Vice President of federal products for Medicare & Retirement.

Tom Roos has served as Senior Vice President and Chief Accounting Officer of UnitedHealth Group since August 2015. Prior to joining UnitedHealth Group, Tom was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm.

Chris Zaetta has served as Executive Vice President, Chief Legal Officer and Corporate Secretary of UnitedHealth Group since May 2024. Previously, Chris served as Chief Legal Officer of Optum from September 2020 until May 2024. Prior to joining Optum in 2020, Chris was Vice President at Johnson & Johnson, a pharmaceutical company. Chris also held several leadership roles at UnitedHealth Group from May 2011 to September 2019, including Head of Litigation and General Counsel of the organization's government businesses.

ADDITIONAL INFORMATION

Our executive offices are located at 1 Health Drive, Eden Prairie, Minnesota 55344 and 655 New York Avenue, Washington, DC 20001; our telephone number is (800) 328-5979. You can access our website at www.unitedhealthgroup.com to learn more about our company. We make periodic and current reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law, we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business, which investors and others should consider. We do not undertake to address in future filings with the SEC or other communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in our previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other SEC filings or public statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions which are difficult to predict or quantify.

Risks Related to Our Business and Our Industry

If we fail to estimate, price for and manage our medical costs or design benefits in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. The profitability of our products depends in large part on our ability to predict and effectively price for and manage medical costs. Our Optum Health business also enters into fully accountable value-based arrangements with payers. Premium revenues from risk-based products constitute nearly 80% of our total consolidated revenues. Estimates of benefit expense payments involve extensive judgement and are subject to considerable inherent variability. Relatively small differences between predicted and actual medical costs, or utilization rates as a percentage of revenues, have resulted and in the future may result in significant changes in our financial results. If we fail to predict accurately, or effectively price for or manage, the costs of providing care under risk-based arrangements, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of competitive provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Although we base the premiums we charge on our estimates of future medical costs over the fixed contract period, many factors may cause, and have previously caused, actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, business mix, unexpected differences among new customer populations, increased cost of individual services, costs to deliver care, large-scale medical emergencies, the potential effects of climate change, pandemics, the introduction of new or costly drugs or increases in drug prices, treatments and technology, new treatment guidelines, newly mandated benefits or other regulatory changes and insured population characteristics. Cost increases in excess of our forecasts typically cannot be recovered in the fixed premium period through higher premiums. For Optum Health’s fully accountable value-based care, any inability to provide higher-quality outcomes and better experiences at lower costs or to integrate our care delivery models could impact our results of operations, financial positions and cash flows.

In addition, the financial results we report for any particular period include estimates of costs incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our business depends on the integrity and timeliness of the data we use to serve our members, customers and health care professionals and to operate our business. If the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to effectively maintain or protect the integrity of our data and information systems, including systems powered by or incorporating artificial intelligence and machine learning (AI/ML), we could experience failures in our health, wellness and information technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other health care professionals; become subject to regulatory sanctions, penalties, investigations or audits; incur increases in operating expenses; or suffer other adverse consequences.

The volume of health care data generated, and the uses of data, including electronic health records, are rapidly expanding. We depend on the integrity of the data in our information systems to implement new and innovative services, automate and deploy new technologies to simplify administrative processes and clinical decision making, price our products and services adequately, provide effective service to our customers and consumers in an efficient and uninterrupted fashion, provide timely payments to care providers, and accurately report our results of operations. In addition, increasing connectivity among technologies and recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices and new tools and products that leverage AI/ML to improve the customer experience. We anticipate that fast-evolving AI/ML technologies, including generative AI, will play an increasingly important role in our information systems and customer-facing technology products. Our ability to protect and enhance existing systems and develop new systems to keep pace with changes in information processing technology (including AI/ML), regulatory standards and changing customer preferences will require an ongoing commitment of significant development and operational resources. If these commitments fail to provide the anticipated benefits, if we are unable to successfully anticipate future technology developments, or if the cost to keep pace with the technological changes exceeds our estimates, we could be exposed to reputational harm and experience adverse effects on our business.

We may not successfully implement our initiatives to consolidate the number of systems we operate, upgrade and expand our information systems' capabilities, integrate and enhance our systems and develop new systems to keep pace with recent regulations and changes in information processing technology. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs.

Some of our businesses sell and install software products which may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to health data and health information technologies, including those powered by or incorporating AI/ML, may alter the competitive landscape or impose new compliance requirements and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in our markets.

If we or third parties we rely on sustain cyberattacks or other privacy or data security incidents resulting in disruption to our operations or the disclosure of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, negative operational effects, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information subject to privacy, security or data breach notification laws, as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyberattacks and other security threats and have previously been, and may in the future be, subject to compromises of the information technology systems we use, information we hold, or information held on our behalf by third parties. For example, we previously reported our Change Healthcare business, which we had recently acquired, was subject to a cyberattack in 2024, in which the data involved contained protected health information or personally identifiable information.

While we have programs in place to detect, contain and respond to data security incidents and provide employee awareness training regarding phishing, malware and other cyber threats to protect against cybersecurity risks and incidents, we expect that we will continue to experience these incidents, some of which may negatively affect our business. Further, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and are increasing in sophistication, in part due to use of evolving AI/ML technologies (including generative AI), and because our businesses are changing as well, we may be unable to anticipate these techniques and threats, timely detect data security

incidents or implement adequate preventive measures. Threat actors and hackers have previously been, and may in the future be, able to negatively affect our operations by penetrating our security controls and causing system and operational disruptions or shutdowns, accessing, misappropriating or otherwise compromising protected personal information or proprietary or confidential information or that of third parties, and developing and deploying viruses, ransomware and other malware that can attack our systems, exploit any security vulnerabilities, and disrupt or shutdown our systems and operations. In addition, hardware, software, or applications we develop or procure from third parties may contain defects or other problems which could unexpectedly compromise our information security controls. Our systems may also be vulnerable to financial fraud schemes, misplaced or lost data, error, malicious social engineering, or other events which could negatively affect the data or financial accounts, proprietary or confidential information relating to our business or third parties, or our operations. There have previously been and may be in the future heightened vulnerabilities due to recently-acquired or non-integrated businesses. We rely in some circumstances on third-party vendors to process, store and transmit large amounts of data for our business. The operations of these vendors are subject to similar risks, but are outside our direct oversight and control.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cybersecurity incident could be material. We have business continuation and resiliency plans which we maintain, update and test regularly in an effort to contain and remediate potential disruptions or cybersecurity events. If our remediation efforts are not successful, we may experience operational interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, compromises of our security measures or the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us, our customers or other third parties, previously and in the future, could expose us or them to the risk of financial or medical identity theft, negative operational impacts, and loss or misuse of this information, result in litigation and liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to develop and maintain satisfactory relationships with health care payers, physicians, hospitals and other service providers, our business could be materially and adversely affected.

We depend substantially on our continued ability to contract with health care payers (as a service provider to those payers), as well as physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other care and service providers at competitive prices. If we fail to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, our failure to do so could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, some of our activities related to network design, provider participation in networks and provider payments could result in disputes, which may be costly and attract negative publicity.

In any particular market, physicians and health care providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions which could diminish our bargaining power. In addition, Accountable Care Organizations (ACOs); physician group management services organizations (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way we price our products and estimate our costs, which might require us to incur costs to change our operations in an effort to mitigate these impacts. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have risk-based arrangements with some physicians, hospitals and other health care providers. These arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care providers. To the extent a risk-based health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the arrangement, we may be held responsible for unpaid health care claims which should have been the responsibility of the health care provider and for which we have already paid the provider. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. They may also fail to provide us with the information we need to effectively conduct our businesses, such as information enabling us to estimate costs of care. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In some instances, those providers may dispute the payment for these services and may institute litigation or arbitration relying on state and federal laws that define the compensation that must be paid to out-of-network providers in some circumstances.

The success of some of our businesses depends on maintaining satisfactory relationships with employed, affiliated, and independently contracted physicians and joint venture partners. The physicians who practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. We face and will likely continue to face heightened competition to acquire or manage physician practices or to employ or contract with individual physicians. Our revenues could be materially and adversely affected if we are unable to maintain or expand satisfactory relationships with physicians, to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following physician departures. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with or fail to adequately price their contracts with these third-party payer competitors.

Further, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses face significant competition in all of the markets in which we operate. In many geographies or product segments, our competitors have and may continue to have certain competitive advantages. Our competitive position may also be adversely affected by significant merger and acquisition activity in the industries in which we operate, among both our competitors and suppliers. Consolidation among competitors may make it more difficult for us to retain or increase our customer base, maintain or improve the terms on which we do business with our suppliers, or maintain or increase our profitability.

In addition, our success in the health care marketplace and future growth depends on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services which are useful and relevant to health care payers, consumers and our customers, we may not remain competitive and risk losing market share to existing competitors and disruptive new market entrants. We may face risks from new technologies and market entrants which could affect our existing relationship with health plan enrollees in the affected markets. We could sustain competitive disadvantages and loss of market share if we fail to continue developing innovative care models, including by accelerating the transition of care to value-based models that achieve higher quality outcomes and better experiences at lower costs and expand access to virtual and in-home care. If health care payers or providers are unwilling or unable to enter into value-based agreements with us, we may be unable to successfully establish or maintain the contractual or employment relationships necessary to achieve the quality and cost objectives we have for value-based contracting. Additionally, our competitive position could be adversely affected by any failure to develop and apply innovative technologies and other effective data and analytics capabilities or to provide services to our clients focused on these technologies and capabilities.

Our business, results of operations, financial position and cash flows also could be materially and adversely affected if we do not compete effectively in our markets, if our reputation suffers harm, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services demonstrating value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

We are routinely subject to various private party and governmental legal actions and investigations, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of private party and governmental legal actions and investigations related to, among other matters, the design, management and delivery of our product and service offerings. Any failure by us to adhere to the laws and regulations applicable to our businesses could subject us to civil and criminal penalties.

Legal actions to which we are a party have included and in the future could include matters related to health care benefits coverage and payment of claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by personnel at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks, including as a result of a failure to adhere to applicable clinical, quality and/or patient safety standards), antitrust claims (including as a result of changes in the

enforcement of antitrust laws), whistleblower claims (including claims under the False Claims Act or similar statutes), matters related to our use of or alleged failure to adequately safeguard personal information or other proprietary data, claims related to alleged failure of our technology products to operate properly or fairly, contract and labor disputes, tax claims and claims related to disclosure of certain business practices. In addition, some of our pharmacy services operations are subject to clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs, including claims related to purported dispensing and other operational errors. We may also be party to certain class action lawsuits brought by health care professional groups and consumers. We operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others.

We are largely self-insured with regard to litigation risks, including claims of medical malpractice against our affiliated physicians and us. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible the level of actual losses will significantly exceed the liabilities recorded. Additionally, physicians and other healthcare providers have become subject to an increasing number of legal actions alleging medical malpractice and general professional liabilities. Even in states that have imposed caps on damages for such actions, litigants are seeking recoveries under theories of liability that might not be subject to the caps on damages. These actions involve significant defense costs and could result in substantial monetary damages or damage to our reputation.

We cannot predict the outcome of significant legal actions in which we are involved. Even in situations where we engage external insurers, our coverage may be disputed or may not be sufficient to cover the entirety of certain claims. We incur expenses to resolve these matters and current and future legal actions could further increase our cost of doing business, require us to potentially change the way we conduct our business, and materially and adversely affect our results of operations, financial position and cash flows. Moreover, certain legal actions could result in adverse publicity which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Our business could suffer, and our results of operations, financial position and cash flows could be materially and adversely affected, if we fail to successfully manage our strategic alliances, or to complete, manage or integrate acquisitions and other significant strategic transactions or relationships.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, governmental actions, such as actions by the FTC or DOJ, may affect our ability to complete strategic transactions, which could adversely affect our future growth. If we fail to identify and successfully complete transactions to meet our strategic objectives, including as a result of antitrust regulatory enforcement actions, such as those that have been brought against us in the past, we may be required to expend resources to develop products and technology internally, be placed at a competitive disadvantage or be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Successful acquisitions also require us to effectively integrate the acquired business into our existing operations, including our internal control environment and culture, or otherwise leveraging its operations which may present risks different from those presented by organic growth and may be difficult for us to manage. For example, we have experienced and in the future may encounter more acute information technology system vulnerabilities or different litigation risk profiles in recently acquired business than we have historically managed. We may be unable to address such vulnerabilities, inadequacies, differences, or failures soon after acquiring a business, which could undermine integration activities, delay launch of acquired products, and increase infrastructure risk. In addition, even with appropriate diligence, pre-acquisition practices of an acquired business have exposed us in the past and may expose us in the future to legal challenges and investigations that could subject us to criminal fines or reputational harm. Even if we are ultimately successful in resolving these matters, defending such claims may be costly and result in negative publicity. If we cannot successfully integrate our acquired businesses and realize contemplated revenue growth opportunities, cost savings and other synergies, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

We are subject to risks associated with public health crises arising from large-scale medical emergencies, pandemics, natural disasters and other extreme events, which have had and could have an adverse effect on our business, results of operations, financial condition and financial performance.

Large-scale medical emergencies, pandemics, natural disasters, public health crises and other extreme events could have a material adverse effect on our business operations, cash flows, financial conditions and results of operations. For example, disruptions in public and private infrastructure resulting from such events could increase our operating costs and impair our ability to provide services to our clients and customers. In addition, as a result of these events, the premiums and fees we charge may not be sufficient to cover our medical and administrative costs, deferred medical care could be sought in future periods at potentially higher acuity levels, we could experience reduced demand for our services, and our clinical and non-clinical workforce could be affected and sustain a reduced capacity to handle demand for care. Public health crises arising from natural disasters, such as wildfires, hurricanes, and snowstorms, or effects of climate change could impact our business operations and result in increased medical care costs. Government enactment of emergency powers in response to public health crises could disrupt our business operations, including by restricting availability of, or our ability to deliver, pharmaceuticals or other supplies, and could increase the risk of shortages of necessary items.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales could be materially and adversely affected if we are unable to attract, retain and support independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be impaired by changes in our business practices and the terms of our relationships, including commission levels.

Our businesses are subject to risks associated with unfavorable economic conditions.

Unfavorable economic conditions may have a range of impacts on the demand for our products and services. Such conditions also have caused and in future periods could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer particular coverage on a voluntary, employee-funded basis to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in people served and in the premium and fee revenues we generate.

A prolonged unfavorable economic environment could constrain state and federal budgets and result in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retroactively to apply to payments already negotiated or received from the government. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment could also adversely impact the financial position of hospitals and other care providers which could negatively affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could have a material adverse effect on our financial results by impacting the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others.

Our failure to attract, develop, retain, and manage the succession of key employees and executives could adversely affect our business, results of operations and future performance.

We depend on our ability to attract, develop and retain qualified employees and executives, including those with diverse talents, backgrounds, experiences and perspectives, to operate and expand our business. While we have development and succession plans in place for our key employees and executives, these plans do not guarantee that the services of our key employees and executives will continue to be available to us. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected. Experienced and highly skilled employees and executives in the health care and technology industries are in high demand and the market for their services is competitive. We may have difficulty in replacing key executives because of the limited number of qualified individuals in these industries with the breadth of skills and experience required to operate and successfully expand our business. Adverse changes to our corporate culture could harm our business operations and our ability to retain key employees and executives.

Our investment portfolio may sustain losses which could adversely affect our profitability.

Market fluctuations could impair the value of our investment portfolio and our profitability. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities which constitute the substantial majority of the fair value of our investments as of December 31, 2024. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments which could adversely affect our profitability and equity.

Our investments may not produce total positive returns and we may sell investments at prices which are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial or market conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it should become necessary for us to liquidate a material portion of our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2024, our goodwill and other intangible assets had a carrying value of \$130 billion, representing 44% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses we acquire perform in a manner inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely affect our credit ratings.

If we are not able to protect our proprietary rights to our databases, software and related products, or other intellectual property, our ability to market our knowledge and information-related businesses could suffer.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, intellectual property rights inherent in software are the subject of substantial litigation, and we expect our software products to be increasingly subject to third-party infringement claims as the number of products and competitors in the health care-focused software industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services which could materially and adversely affect our results of operations, financial position and cash flows.

Any downgrades in our credit ratings could increase our borrowing and operating costs.

Claims paying ability, financial strength and debt ratings by nationally recognized statistical rating organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. We may not be able to maintain our current credit ratings in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

Risks Related to the Regulation of Our Business

Our business activities in the United States and other countries are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including regulations and licensure requirements related to PPOs, MCOs, UR and TPAs. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies which write the same line or similar lines of business. Any such assessment could expose our

insurance entities and other insurers to the risk they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Some of our businesses provide products or services to government agencies. For example, some of our Optum and UnitedHealthcare businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of our contracts with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies which might be viewed to involve an actual or potential conflict of interest. These laws and regulations may limit our ability to pursue and perform certain types of engagements, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Some of our Optum businesses are also subject to regulations distinct from those faced by our insurance and HMO subsidiaries, some of which could impact our relationships with physicians, hospitals and customers. These regulations include state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine restrictions; fee-splitting rules; and health care facility licensure and certificate of need requirements. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to achieve targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent and often unpredictable change. For example, legislative, administrative and public policy changes to the ACA have been and likely will continue to be considered, and we cannot predict if the ACA will be further modified. Additionally, changes in tax laws or unfavorable resolutions of exams could create additional tax liabilities.

The integration of entities we acquire into our businesses may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules which did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could compel us to change how we do business, renegotiate existing contracts and other arrangements, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, resolution of commercial disputes and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for some regulated products and services and complete or integrate strategic transactions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on proposed rate increases to HHS on many of our products for monitoring purposes. Geographic and product expansions of our businesses may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

We also currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relationships with non-U.S. regulators could adversely affect our ability to market our products and services or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations. Non-U.S. regulatory regimes, which vary by jurisdiction, encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers). Any foreign regulator or court may take an approach to the interpretation, implementation and enforcement of industry regulations which could differ from the approach taken by U.S. regulators or courts. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating outside the United States, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate concerning industry regulation. Negative publicity may adversely affect our stock price, damage our reputation, and expose us to unexpected or unwarranted regulatory scrutiny.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations which could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Some of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, has affected and in future periods may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate are generally subject to frequent changes, including changes which may reduce the number of persons enrolled or eligible for coverage (such as Medicaid eligibility redeterminations in certain states), reduce the amount of reimbursement or payment levels, reduce our participation in, or prevent our expansion into, certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS in the past has reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit. States have also made changes in rates and reimbursements for Medicaid members and audits can result in unexpected recoupments.

Under the Medicaid managed care program, state Medicaid agencies solicit bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members who were enrolled in those Medicaid programs. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. Chronic failure to meet the benchmarks could result in termination of these government contracts. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions are materially incorrect, either as a result of unforeseen changes to the programs on which we bid, implementation of material program or policy changes after our bid submission, or submissions by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs we participate in are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system providing various quality bonus payments to Medicare Advantage plans meeting specified quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management, handling of appeals and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments, and CMS has and may make changes to the star rating program that impact the ability of plans to achieve four-star or higher ratings. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits our plans can offer, which could materially and adversely affect the marketability of our plans and the number of people we serve. Any changes in standards or care delivery models applying to government health care programs, including Medicare and Medicaid, or our inability to maintain or improve our quality scores and star ratings to meet evolving government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding and adjust monthly capitation payments for Medicare programs. For Medicare Advantage plans, these adjustments are made according to the predicted health status of each beneficiary as supported by data from health care providers. For Medicare Part D plans, payment adjustments are driven by risk-sharing provisions based on a comparison of costs forecasted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for

purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Some of our local plans have been selected for such audits, which in the past have resulted and in future periods could result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and in the future may become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Such investigations, audits, reviews or assessments sometimes arise out of, or prompt claims by private litigants or whistleblowers regarding, among other allegations, claims that we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Government investigations, audits, reviews and assessments could lead to government actions, which have resulted and in future periods could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

Our pharmacy care services businesses face regulatory and operational risks and uncertainties which may differ from the risks of our other businesses.

We provide pharmacy care services through our Optum Rx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws governing the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry which could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Further, various governmental agencies have conducted and continue to conduct investigations and studies into certain PBM practices, which have resulted and in future periods may result in PBMs agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements, or could materially and adversely impact the PBM business model. As a provider of pharmacy benefit management services, Optum Rx is also subject to an increasing number of licensure, registration and other laws and accreditation standards. Optum Rx conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the Food and Drug Administration and Boards of Pharmacy.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, as well as claims related to the inherent risks in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine such fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims we entered into prohibited transactions.

If we fail to comply with applicable privacy, security, technology and data laws, regulations and standards, including with respect to third-party service providers utilizing protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information are regulated at the federal, state, international and industry levels and addressed in requirements of our customer contracts. Additionally, legislative and regulatory action in the United States at the federal, state and local levels, as well as internationally, is emerging in the areas of AI/ML and automation. These laws, regulations and requirements are subject to change. Compliance with new privacy, security, technology and data laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection, information security, and AI/ML and automation in the European Union, UK, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers.

Some of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard designed to protect payment card account data.

HIPAA requires business associates as well as covered entities to comply with specified privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. If HHS alleges or finds noncompliance with HIPAA privacy or security requirements, the allegations or findings could damage our reputation and subject us to monetary and other sanctions.

Through our Optum businesses, we maintain a database of administrative and clinical data statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have an adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to affected customers and the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents, and could also result in significant fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

As an enterprise, we increasingly rely on new and evolving technologies, including those powered by or incorporating AI/ML, as part of our internal operations and in the delivery of our products and services. New technologies have potential and power to improve and optimize operational processes and clinical outcomes across the healthcare system, but also present ethical, technological, legal, regulatory and other risks. With respect to AI/ML, we have developed and implemented policies and procedures intended to promote and sustain responsible design, development, and use of AI/ML, consistent with industry best practices. Any inadequacy or failure in compliance with our responsible use of AI/ML policies and procedures or emerging laws, regulations and standards governing AI/ML use could cause our technology products not to operate as intended or to produce outcomes, including possible regulatory enforcement action or litigation that could have a material and adverse effect on our business, reputation, results of operations, financial position and cash flows.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our ability to reinvest in our business, service our debt and return capital to our shareholders.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by state departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries exceeding specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 1C. CYBERSECURITY

UnitedHealth Group manages cybersecurity and data protection through a continuously evolving framework. The framework allows us to identify, assess and mitigate the risks we face, and assists us in establishing policies and safeguards to protect our systems and the information of those we serve.

Our cybersecurity program is managed by our Chief Digital and Technology Officer and our Chief Security Officer. The Audit and Finance Committee of the Board of Directors has oversight of our cybersecurity program and is responsible for reviewing and assessing the effectiveness of the Company's cybersecurity and data protection policies, procedures and resource commitment, including key risk areas and mitigation strategies. As part of this process, the Audit and Finance Committee receives regular updates from the Chief Digital and Technology Officer and the Chief Security Officer on critical issues related to our information security risks, cybersecurity strategy, supplier risk and business continuity capabilities. The Audit and Finance Committee has also added a leading cybersecurity incident and response firm to serve as its advisor on cybersecurity matters.

The Company's framework includes an incident management and response program that continuously monitors the Company's information systems for vulnerabilities, threats and incidents; manages and takes action to contain incidents that occur; remediates vulnerabilities; and communicates the details of significant threats and incidents to management, including the Chief Digital and Technology Officer and the Chief Security Officer, as deemed necessary or appropriate. Pursuant to the Company's incident response plan, incidents are reported to the Audit and Finance Committee and appropriate government agencies and other authorities, as deemed necessary or appropriate, considering the actual or potential impact, significance and scope.

We require our third-party partners and contractors to handle data in accordance with our data privacy and information security requirements and applicable laws. We regularly engage with our suppliers, partners, contractors, service providers and internal development teams to identify and remediate vulnerabilities in a timely manner and monitor system upgrades to mitigate future risk, and evaluate whether they employ appropriate and effective controls and continuity plans for their systems and operations.

To ensure that our program is designed and operating effectively, our infrastructure and information systems are audited periodically by internal and external auditors. We have obtained various certifications from industry-recognized certifying organizations as a result of certain external audits. We also perform regular vulnerability assessments and penetration tests to improve system security and address emerging security threats. Our internal audit team independently assesses security controls against our enterprise policies to evaluate compliance and leverages a combination of auditing and security frameworks to evaluate how leading practices are applied throughout our enterprise. Audit results and remediation progress are reported to and monitored by senior management and the Audit and Finance Committee. We also periodically partner with industry-leading cybersecurity firms to assess our cybersecurity program. These assessments complement our other assessment work by evaluating our cybersecurity program as a whole.

We complete an enterprise information risk assessment as part of our overall enterprise information security risk management assessment, which is overseen by our Chief Security Officer. This risk assessment is a review of internal and external threats that evaluates changes to the information risk landscape to inform the investments and program enhancements to be made in the future to rapidly respond and recover from potential attacks, including rebuild and recovery protocols for key systems. We evaluate our enterprise information security risk to address unexpected or unforeseen changes in the risk environment or our systems and the resulting impacts are communicated to the Company's overall enterprise risk management program.

We believe our Chief Digital and Technology Officer and our Chief Security Officer have the appropriate knowledge and expertise to effectively manage our cybersecurity program. The Chief Digital and Technology Officer has experience leading enterprise digital transformation efforts for a large multinational corporation and held several leadership and growth positions at a global technology consulting and services firm before joining UnitedHealth Group. Our Chief Security Officer has more than 30 years of experience as a security professional in both the private and public sectors, including in law enforcement. Prior to joining UnitedHealth Group, he served in security leadership roles at several large multinational corporations and has additionally served on cybersecurity advisory boards for some of the largest corporations in the country.

As of December 31, 2024, the Company has not identified any risks from cybersecurity threats that have materially affected or are reasonably likely to materially affect the Company, including our business strategy, results of operations or financial condition, but there can be no assurance that any such risk will not materially affect the Company in the future. For further information about the cybersecurity risks we face, and potential impacts, see Part I, Item 1A, "Risk Factors."

ITEM 2. PROPERTIES

We own and lease real properties to support our business operations in the United States and other countries. Our reportable segments use these facilities for their respective business purposes, and we believe the current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions “Legal Matters” and “Government Investigations, Audits and Reviews” in Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data”

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT’S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2025, there were 9,323 holders of record of our common stock.

DIVIDEND POLICY

In June 2024, our Board of Directors increased the Company’s quarterly cash dividend to shareholders to an annual rate of \$8.40 compared to \$7.52 per share, which the Company had paid since June 2023. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a) Fourth Quarter 2024

For the Month Ended	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)		(in millions)	(in millions)
October 31, 2024	2.6	\$ 568.70	2.6	39.6
November 30, 2024	0.9	593.39	0.9	38.7
December 31, 2024	5.6	513.93	5.6	33.1
Total	<u>9.1</u>	<u>\$ 537.14</u>	<u>9.1</u>	

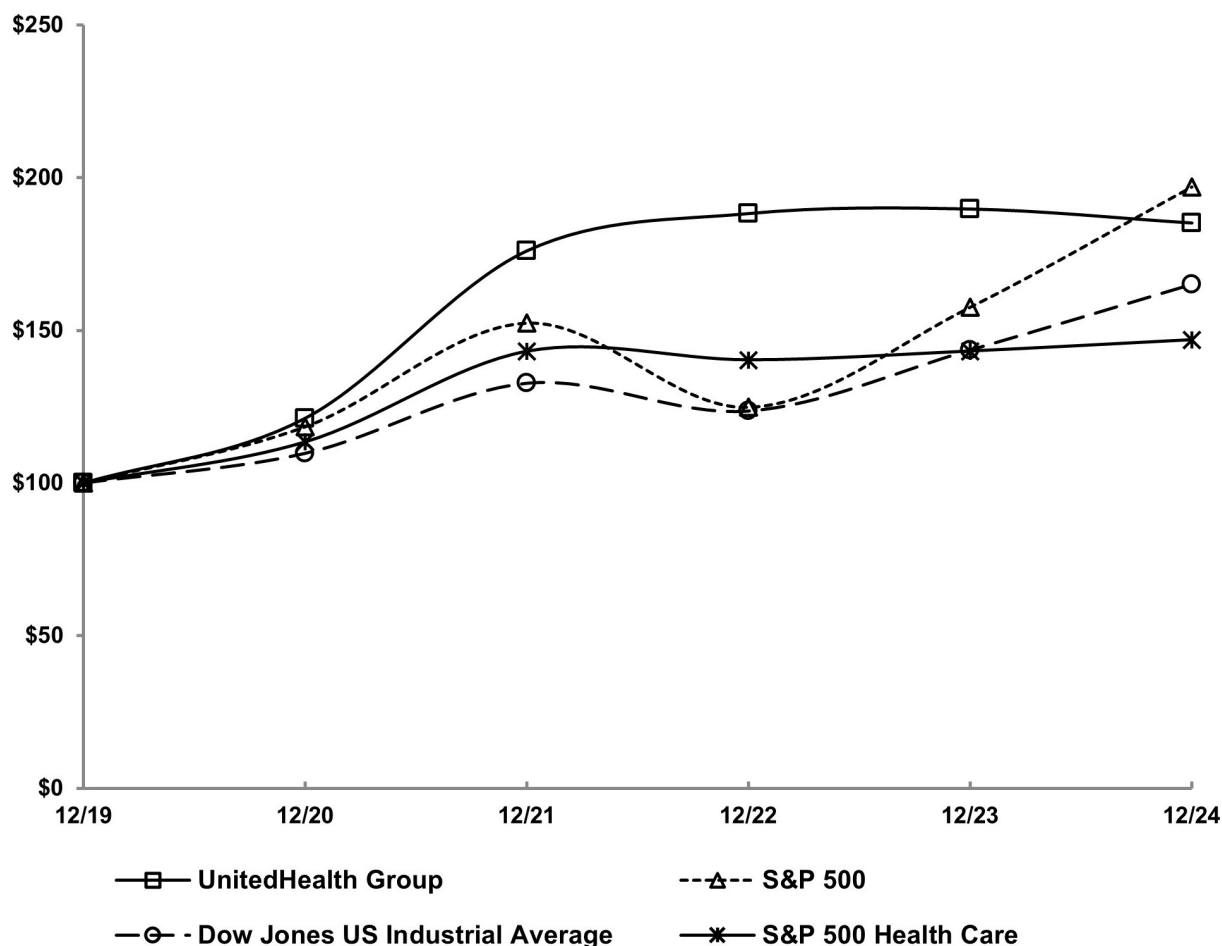
- (a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board of Directors evaluates periodically. In June 2024, the Board of Directors amended our share repurchase program to authorize the repurchase of up to 35 million shares of our common stock in open market purchases or other types of transactions (including prepaid or structured repurchase programs), in addition to all remaining shares authorized to be repurchased under the Board’s 2018 renewal of the program. There is no established expiration date for the program. The Board of Directors from time to time may further amend the share repurchase program in order to increase the authorized number of shares which may be repurchased under the program.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 Index for the five-year period ended December 31, 2024. The comparisons assume the investment of \$100 on December 31, 2019 in our common stock and in each index, and the reinvestment of dividends when paid.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 Index



	12/19	12/20	12/21	12/22	12/23	12/24
UnitedHealth Group	\$ 100.00	\$ 121.20	\$ 176.01	\$ 188.23	\$ 189.73	\$ 185.15
S&P 500 Health Care Index	100.00	113.45	143.09	140.29	143.18	146.87
Dow Jones US Industrial Average	100.00	109.72	132.71	123.60	143.60	165.12
S&P 500 Index	100.00	118.40	152.39	124.79	157.59	197.02

The stock price performance included in this graph is not necessarily indicative of future stock price performance. The preceding stock performance graph shall not be deemed incorporated by reference by any general statement incorporating by reference this Annual Report on Form 10-K into any filing under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, except to the extent that the Company specifically incorporates such information by reference, and shall not otherwise be deemed filed under such Acts.

ITEM 6. RESERVED

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Part II Item 8, "Financial Statements and Supplementary Data." Readers are cautioned the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

Discussions of year-over-year comparisons between 2023 and 2022 are not included in this Form 10-K and can be found in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Company's Form 10-K for the fiscal year ended December 31, 2023.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two distinct, yet complementary businesses — Optum and UnitedHealthcare — are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve.

We have four reportable segments across our two businesses:

- Optum Health;
- Optum Insight;
- Optum Rx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 14 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Change Healthcare Cyberattack

As previously announced, on February 21, 2024, we identified that cybercrime threat actors had gained access to certain Change Healthcare information technology systems. Upon detection of this outside threat, we isolated the impacted systems to protect our partners and customers.

We have substantially mitigated the impact to consumers and care providers of the unprecedented cyberattack on the U.S. health system and restored or replaced the majority of the affected Change Healthcare services. To support care providers we provided interest-free loans of more than \$9 billion through December 31, 2024. For the year ended December 31, 2024, we incurred \$2.2 billion of direct response costs, including costs associated with providing interest-free loans; increased medical care expenditures, as we suspended some care management activities to help care providers with their workflow processes; network restoration; and notifications of impacted persons. Optum Insight also experienced estimated business disruption impacts of \$867 million for the year ended December 31, 2024, reflecting lost revenue while maintaining full readiness of the affected Change Healthcare services. We expect to continue to incur direct response costs and experience business disruption impacts at a lesser extent in 2025 as we work to bring transaction volumes back to pre-event levels and win new business.

We have determined the estimated total number of individuals impacted by the Change Healthcare cyberattack is approximately 190 million. The vast majority of those people have already been provided individual or substitute notice. The final number will be confirmed and filed with the Office for Civil Rights. Change Healthcare is not aware of any misuse of individuals' information as a result of this incident and has not seen electronic medical record databases appear in the data during the analysis. It is possible that future risks and uncertainties resulting from the Change Healthcare cyberattack, including risks related to impacted data, litigation, reputational harm, and regulatory actions could adversely affect our financial condition or results of operations.

Business Trends

Our businesses participate in the United States and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macroeconomic conditions, which could impact our results of operations, including our continued efforts to control health care costs.

Pricing Trends. To price our health care benefits, products and services, we start with our view of expected future costs, including medical care patterns, inflation and labor market dynamics. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum medical loss ratio (MLR) thresholds and similar revenue adjustments. We will continue seeking to balance growth and profitability across all these dimensions.

The commercial risk market remains highly competitive in the small group, large group and individual segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs.

Medicare Advantage funding continues to be pressured, as discussed below in “Regulatory Trends and Uncertainties” and we have observed increased care patterns as discussed below in “Medical Cost Trends.” Our 2025 benefit design approach contemplates these trends.

In Medicaid, we believe the payment rate environment creates the risk of continued downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, care activity and prescription drug costs. As expected and contemplated in our benefits design, we have continued to observe increased care patterns, which may continue in future periods. We also observed an upshift in hospital coding intensity and an acceleration in the prescribing of certain high-cost medications in early response to the Inflation Reduction Act (IRA). We expect these additional factors to continue into future periods. We endeavor to mitigate those increases by engaging hospitals, physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

As a result of the Change Healthcare cyberattack, we incurred medical costs related to the impact of the temporary suspension of some care management activities, impacting our UnitedHealthcare and Optum Health businesses, to help care providers with their workflow processes. Early in the second quarter we resumed these activities. For the year ended December 31, 2024, medical costs related to the temporary suspension of some care management activities were approximately \$640 million.

Medicaid Redeterminations. Medicaid redeterminations have impacted the number of people served through our Medicaid offerings, partially offset by an increase in consumers served through our commercial offerings as we endeavor to ensure that people and families have continued access to care. The Medicaid redetermination process has also caused a timing mismatch between the current health status of people served through Medicaid and state rate updates, which remained well short of current care activity. We expect this gap between people’s health status and rates will narrow in 2025.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality and patient experience, improve the health of populations and reduce costs. We are working to accelerate this vision through the innovation and integration of our care delivery models including in-clinic, in-home, behavioral and virtual care, and by using our data and analytics to provide clinicians with the necessary information in order to provide the best possible care in the most cost efficient setting. We continue to see a greater number of people enrolled in fully accountable value-based plans rewarding high-quality, affordable care and fostering collaboration.

This trend is creating needs for health management services which can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform. A key focus of our future growth is to accelerate the transition from fee-for-service care delivery and payment models to fully accountable value-based care. This transition requires initial costs such as system enhancements, integrated care coordination technology, physician training and clinical engagement. Enhanced clinical engagement is a critical step to improving the experience and health outcomes of the people we serve and should result in lower costs to the overall health system over time.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to regulatory matters. For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business - Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Medicare Advantage rate notices over the years have at times resulted in industry base rates well below industry forward medical trend. For example, the Final Notice for 2024 and 2025 rates resulted in an industry base rate decrease, both of which are well short of what is an increasing industry forward medical cost trend. The Advance Notice for 2026 rates proposes an industry base rate increase also well short of forward medical cost trend, creating continued pressure in the Medicare Advantage program. Further, substantial revisions to the risk adjustment model, which serves to adjust rates to reflect a patient's health status and care resource needs, will result in reduced funding and potentially benefits for people, especially those with some of the greatest health and social challenges.

As a result of ongoing Medicare funding pressures, there are adjustments we can make to partially offset these rate pressures and reductions for a particular period. For example, we can seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust member benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

SELECTED OPERATING PERFORMANCE ITEMS

The following summarizes select 2024 year-over-year operating comparisons to 2023 and other financial results.

- Consolidated revenues grew 8%, UnitedHealthcare revenues grew 6% and Optum revenues grew 12%.
- UnitedHealthcare served 2.1 million more people domestically, driven by growth in commercial offerings, partially offset by the impact of Medicaid redeterminations.
- Earnings from operations of \$32.3 billion compared to \$32.4 billion last year.
- Diluted earnings per common share was \$15.51, impacted by the loss on sale of subsidiary and subsidiaries held for sale.
- Cash flows from operations were \$24.2 billion.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31,			Change	
	2024	2023	2022	2024 vs. 2023	
Revenues:					
Premiums	\$ 308,810	\$ 290,827	\$ 257,157	\$ 17,983	6%
Products	50,226	42,583	37,424	7,643	18
Services	36,040	34,123	27,551	1,917	6
Investment and other income	5,202	4,089	2,030	1,113	27
Total revenues	400,278	371,622	324,162	28,656	8
Operating costs:					
Medical costs	264,185	241,894	210,842	22,291	9
Operating costs	53,013	54,628	47,782	(1,615)	(3)
Cost of products sold	46,694	38,770	33,703	7,924	20
Depreciation and amortization	4,099	3,972	3,400	127	3
Total operating costs	367,991	339,264	295,727	28,727	8
Earnings from operations	32,287	32,358	28,435	(71)	—
Interest expense	(3,906)	(3,246)	(2,092)	(660)	20
Loss on sale of subsidiary and subsidiaries held for sale	(8,310)	—	—	(8,310)	nm
Earnings before income taxes	20,071	29,112	26,343	(9,041)	(31)
Provision for income taxes	(4,829)	(5,968)	(5,704)	1,139	(19)
Net earnings	15,242	23,144	20,639	(7,902)	(34)
Earnings attributable to noncontrolling interests	(837)	(763)	(519)	(74)	10
Net earnings attributable to UnitedHealth Group common shareholders	\$ 14,405	\$ 22,381	\$ 20,120	\$ (7,976)	(36)%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	\$ 15.51	\$ 23.86	\$ 21.18	\$ (8.35)	(35)%
Medical care ratio (a)	85.5 %	83.2 %	82.0 %	2.3 %	
Operating cost ratio	13.2	14.7	14.7	(1.5)	
Operating margin	8.1	8.7	8.8	(0.6)	
Tax rate	24.1	20.5	21.7	3.6	
Net earnings margin (b)	3.6	6.0	6.2	(2.4)	
Return on equity (c)	15.9 %	27.0 %	27.2 %	(11.1)%	

nm = not meaningful

(a) Medical care ratio (MCR) is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group common shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2024 RESULTS OF OPERATIONS COMPARED TO 2023 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues were primarily driven by growth in Optum Rx, UnitedHealthcare's domestic offerings and Optum Health, partially offset by the sale of UnitedHealthcare's Brazil operations.

Medical Costs and MCR

Medical costs increased primarily due to growth in people served through Medicare Advantage and domestic commercial offerings and member mix. The MCR increased as a result of the revenue effects of the Medicare funding reductions, Medicaid timing mismatch between people's health status and rates, upshift in hospital coding intensity, specialty pharmaceutical prescribing patterns, member mix and due to incremental medical costs for accommodations made to care providers as a result of the Change Healthcare cyberattack.

Operating Cost Ratio

The operating cost ratio decreased primarily due to operating cost management and gains related to business portfolio refinement, including strategic transactions, partially offset by the impact of our direct response efforts to the Change Healthcare cyberattack and investments to support future growth.

Loss on Sale of Subsidiary and Subsidiaries Held for Sale

On February 6, 2024, the Company completed the sale of its Brazil operations. During the year ended December 31, 2024, we recorded a loss of \$7.1 billion, of which \$4.1 billion related to the impact of cumulative foreign currency translation losses previously included in accumulated other comprehensive loss.

In the second quarter of 2024, the Company initiated a plan to sell its remaining South American operations, which were classified as held for sale as of December 31, 2024. During the year ended December 31, 2024, we recorded a loss of \$1.2 billion, of which \$855 million related to the impact of cumulative foreign currency translation losses.

Reportable Segments

See Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for more information on our segments. We utilize various metrics to evaluate and manage our reportable segments, including individuals served by UnitedHealthcare by major market segment and funding arrangement, people served by Optum Health and adjusted scripts for Optum Rx. These metrics are the main drivers of revenue, earnings and cash flows at each business. The metrics also allow management and investors to evaluate and understand business mix, including the level and scope of services provided to people and pricing trends when comparing the metrics to revenue by segment.

The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31,			Change	
	2024	2023	2022	2024 vs. 2023	
Revenues					
UnitedHealthcare	\$ 298,208	\$ 281,360	\$ 249,741	\$ 16,848	6%
Optum Health	105,358	95,319	71,174	10,039	11
Optum Insight	18,757	18,932	14,581	(175)	(1)
Optum Rx	133,231	116,087	99,773	17,144	15
Optum eliminations	(4,389)	(3,703)	(2,760)	(686)	19
Optum	252,957	226,635	182,768	26,322	12
Eliminations	(150,887)	(136,373)	(108,347)	(14,514)	11
Consolidated revenues	<u>\$ 400,278</u>	<u>\$ 371,622</u>	<u>\$ 324,162</u>	<u>\$ 28,656</u>	8%
Earnings from operations					
UnitedHealthcare	\$ 15,584	\$ 16,415	\$ 14,379	\$ (831)	(5)%
Optum Health	7,770	6,560	6,032	1,210	18
Optum Insight	3,097	4,268	3,588	(1,171)	(27)
Optum Rx	5,836	5,115	4,436	721	14
Optum	16,703	15,943	14,056	760	5
Consolidated earnings from operations	<u>\$ 32,287</u>	<u>\$ 32,358</u>	<u>\$ 28,435</u>	<u>\$ (71)</u>	— %
Operating margin					
UnitedHealthcare	5.2 %	5.8 %	5.8 %	(0.6)%	
Optum Health	7.4	6.9	8.5	0.5	
Optum Insight	16.5	22.5	24.6	(6.0)	
Optum Rx	4.4	4.4	4.4	—	
Optum	6.6	7.0	7.7	(0.4)	
Consolidated operating margin	8.1 %	8.7 %	8.8 %	(0.6)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31,			Change	
	2024	2023	2022	2024 vs. 2023	
UnitedHealthcare Employer & Individual - Domestic	\$ 74,489	\$ 67,187	\$ 63,599	\$ 7,302	11 %
UnitedHealthcare Employer & Individual - Global	3,667	9,307	8,668	(5,640)	(61)
UnitedHealthcare Employer & Individual - Total	78,156	76,494	72,267	1,662	2
UnitedHealthcare Medicare & Retirement	139,482	129,862	113,671	9,620	7
UnitedHealthcare Community & State	80,570	75,004	63,803	5,566	7
Total UnitedHealthcare revenues	<u>\$ 298,208</u>	<u>\$ 281,360</u>	<u>\$ 249,741</u>	<u>\$ 16,848</u>	6 %

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31,			Change	
	2024	2023	2022	2024 vs. 2023	
Commercial - domestic:					
Risk-based	8,845	8,115	8,045	730	9 %
Fee-based	20,885	19,200	18,640	1,685	9
Total commercial - domestic	29,730	27,315	26,685	2,415	9
Medicare Advantage	7,845	7,695	7,105	150	2
Medicaid	7,435	7,845	8,170	(410)	(5)
Medicare Supplement (Standardized)	4,335	4,355	4,375	(20)	—
Total community and senior	19,615	19,895	19,650	(280)	(1)
Total UnitedHealthcare - domestic medical	49,345	47,210	46,335	2,135	5
Commercial - global	1,330	5,540	5,360	(4,210)	(76)
Total UnitedHealthcare - medical	<u>50,675</u>	<u>52,750</u>	<u>51,695</u>	<u>(2,075)</u>	(4)%
Supplemental Data:					
Medicare Part D stand-alone	3,050	3,315	3,295	(265)	(8)%

UnitedHealthcare's revenues increased due to growth in the number of people served through Medicare Advantage and domestic commercial offerings, partially offset by decreased people served globally due to the sale of the Brazil operations and in Medicaid offerings due to redeterminations. Earnings from operations decreased due to Medicare Advantage funding reductions, the impacts of Medicaid redeterminations, member mix and incremental medical costs for accommodations to support care providers as a result of the Change Healthcare cyberattack, partially offset by gains related to business portfolio refinement, including strategic transactions, and the growth in the number of people served through Medicare Advantage and domestic commercial offerings.

Optum

Total revenues increased due to growth at Optum Rx and Optum Health. Earnings from operations increased with growth at Optum Health and Optum Rx, partially offset by decreased earnings from operations at Optum Insight. The results by segment were as follows:

Optum Health

Revenues at Optum Health increased primarily due to organic growth in patients served under value-based care arrangements. Earnings from operations increased due to gains related to business portfolio refinement, including strategic transactions, increased investment income and cost management initiatives, partially offset by Medicare Advantage funding reductions, costs associated with serving newly added patients under value-based care arrangements and medical care activity. Optum Health served approximately 100 million people as of December 31, 2024 compared to 103 million people as of December 31, 2023.

Optum Insight

Revenues at Optum Insight decreased primarily due the business disruption impacts from the Change Healthcare cyberattack, partially offset by growth in technology services. Earnings from operations decreased primarily due to direct response costs and business disruption impacts related to the Change Healthcare cyberattack, partially offset by gains related to business portfolio refinement, including strategic transactions.

Optum Rx

Revenues and earnings from operations at Optum Rx increased due to higher script volumes from both new clients and growth in existing clients and growth in pharmacy services. Earnings from operations also increased due to operating cost efficiencies and supply chain initiatives. Optum Rx fulfilled 1,623 million and 1,542 million adjusted scripts in 2024 and 2023, respectively.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally derived from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to, among other things, minimum levels of statutory capital, as defined by their respective jurisdictions, and restrictions on the timing and amount of dividends paid to their parent companies.

Our U.S. regulated subsidiaries paid their parent companies dividends of \$9.2 billion and \$8.0 billion in 2024 and 2023, respectively. See Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through dividends and repurchases of our common stock.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31,			Change
	2024	2023	2022	2024 vs. 2023
Sources of cash:				
Cash provided by operating activities	\$ 24,204	\$ 29,068	\$ 26,206	\$ (4,864)
Issuances of long-term debt and short-term borrowings, net of repayments	14,660	4,280	12,536	10,380
Proceeds from common share issuances	1,846	1,353	1,253	493
Customer funds administered	—	—	5,548	—
Cash received for dispositions	2,041	685	3,414	1,356
Sales and maturities of investments, net of purchases	525	—	—	525
Total sources of cash	43,276	35,386	48,957	7,890
Uses of cash:				
Cash paid for acquisitions and other transactions, net of cash assumed	(13,408)	(10,136)	(21,458)	(3,272)
Common share repurchases	(9,000)	(8,000)	(7,000)	(1,000)
Cash dividends paid	(7,533)	(6,761)	(5,991)	(772)
Purchases of property, equipment and capitalized software	(3,499)	(3,386)	(2,802)	(113)
Purchases of investments, net of sales and maturities	—	(1,777)	(6,837)	1,777
Purchases of redeemable noncontrolling interests	(280)	(730)	(176)	450
Loans to care providers - cyberattack, net of repayments	(4,519)	—	—	(4,519)
Customer funds administered	(1,560)	(521)	—	(1,039)
Other	(3,312)	(2,110)	(2,737)	(1,202)
Total uses of cash	(43,111)	(33,421)	(47,001)	(9,690)
Effect of exchange rate changes on cash and cash equivalents	(61)	97	34	(158)
Net increase in cash and cash equivalents, including cash within businesses held for sale	\$ 104	\$ 2,062	\$ 1,990	\$ (1,958)
Less: cash within businesses held for sale	(219)	—	—	(219)
Net (decrease) increase in cash and cash equivalents	\$ (115)	\$ 2,062	\$ 1,990	\$ (2,177)

2024 Cash Flows Compared to 2023 Cash Flows

Decreased cash flows provided by operating activities were primarily driven by CMS Medicare funding reductions, Change Healthcare cyberattack response actions, increased medical costs and changes in working capital accounts. Other significant changes in sources or uses of cash year-over-year included increased net issuances of short-term borrowings and long-term debt, net sales and maturities of investments and cash received from dispositions, offset by loans to care providers in response to the Change Healthcare cyberattack, increased cash paid for acquisitions and other transactions, decreased customer funds administered and increased share repurchases.

Financial Condition

As of December 31, 2024, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of \$77.1 billion included \$25.3 billion of cash and cash equivalents (of which approximately \$800 million was available for general corporate use), \$46.9 billion of debt securities and \$4.9 billion of equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is fully supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 4.2 years and a weighted-average credit rating of “Double A” as of December 31, 2024. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

Cash Requirements. The Company's cash requirements within the next twelve months include medical costs payable, accounts payable and accrued liabilities, short-term borrowings and current maturities of long-term debt, other current liabilities, and purchase commitments and other obligations. We expect the cash required to meet these obligations to be primarily generated through cash flows from current operations; cash available for general corporate use; and the realization of current assets, such as accounts receivable.

Our long-term cash requirements under our various contractual obligations and commitments include:

- *Debt obligations.* See Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail of our long-term debt and the timing of expected future payments. Interest coupon payments are typically paid semi-annually.
- *Operating leases.* See Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail of our obligations and the timing of expected future payments.
- *Purchase and other obligations.* These include \$11.5 billion, \$2.4 billion of which is expected to be paid within the next twelve months, of fixed or minimum commitments under existing purchase obligations for goods and services, including agreements cancelable with the payment of an early termination penalty, and remaining capital commitments for venture capital funds, strategic transactions and other funding commitments. These amounts exclude agreements cancelable without penalty and liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2024.
- *Other liabilities.* These include other long-term liabilities reflected in our Consolidated Balance Sheets as of December 31, 2024, including obligations associated with certain employee benefit programs, unrecognized tax benefits and various long-term liabilities, which have some inherent uncertainty in the timing of these payments.
- *Redeemable noncontrolling interests.* See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail. We do not have any material potential required redemptions in the next twelve months.

We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations. However, we also have the ability to generate cash to satisfy both our current and long-term requirements through the issuance of commercial paper, issuance of long-term debt, or drawing under our committed credit facilities or the ability to sell investments. We believe our capital resources are sufficient to meet future, short-term and long-term, liquidity needs.

Short-Term Borrowings. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through independent broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

As of December 31, 2024, we were in compliance with the various covenants under our bank credit facilities.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2024 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt.....	A2	Stable	A+	Stable	A	Stable	A	Stable
Commercial paper.....	P-1	n/a	A-1	n/a	F1	n/a	AMB-1+	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. A significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. In June 2024, our Board of Directors amended our share repurchase program to authorize the repurchase of up to 35 million shares of Common Stock, in addition to all remaining shares authorized to be repurchased under the Board's 2018 renewal of the program. As of December 31, 2024, we had Board of Directors' authorization to purchase up to 33 million shares of our common stock. The Board of Directors from time to time may further amend the share repurchase program in order to increase the authorized number of shares which may be repurchased under the program. For more information on our share repurchase program, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Dividends. In June 2024, our Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of \$8.40 compared to \$7.52 per share. For more information on our dividend, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Pending Acquisitions. As of December 31, 2024, we have entered into agreements to acquire companies in the health care sector, subject to regulatory approval and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately \$4 billion.

We do not have other significant contractual obligations or commitments requiring cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates requiring management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties which are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services rendered on behalf of consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2024, 2023 and 2022 included favorable medical cost development related to prior years of \$700 million, \$840 million and \$410 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim levels and processing cycles, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions), actual care activity incurred (which can be influenced by pandemics or seasonal illnesses, such as influenza), or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2024:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable (in millions)
(0.75)%	\$ 973
(0.50)	647
(0.25)	322
0.25	(321)
0.50	(640)
0.75	(958)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators. These factors include but are not limited to pharmacy utilization trends, inpatient hospital authorization data and seasonal and other incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized; mix of benefits offered, including the impact of co-pays and deductibles; changes in medical practices; and catastrophes, epidemics and pandemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2024:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable (in millions)
3%	\$ 1,264
2	843
1	421
(1)	(421)
(2)	(843)
(3)	(1,264)

The completion factors and medical costs PMPM trend factors analyses above include outcomes considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2024; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2024 estimates of medical costs payable and actual medical costs payable, 2024 net earnings would have increased or decreased by approximately \$260 million.

For more detail related to our medical cost estimates, see Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Goodwill

We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change indicating the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors; cost factors; changes in overall financial performance; and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates a goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a test measuring the fair values of the reporting units and comparing them to their carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

We estimate the fair values of our reporting units using a discounted cash flow method which includes assumptions about a wide variety of internal and external factors. Significant assumptions used in the discounted cash flow method include financial projections of free cash flow, including revenue trends, medical costs trends, operating productivity, income taxes and capital levels; long-term growth rates for determining terminal value beyond the discretely forecasted periods; and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Financial projections and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital reflecting reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. Additionally, as part of our quantitative impairment testing, we perform various sensitivity analyses on certain key assumptions, such as discount rates and cash flow projections to analyze the potential for a material impact. As of October 1, 2024, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts which may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations of investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers constituting our client base. As of December 31, 2024, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates impacting our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt.

As of December 31, 2024, we had \$33 billion of financial assets on which the interest rates received vary with market interest rates, which may significantly impact our investment income. Also as of December 31, 2024, \$27 billion of our financial liabilities, which include debt and deposit liabilities, were at interest rates which vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2024, \$46 billion of our investments were fixed-rate debt securities and \$49 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by matching a portion of our floating-rate assets and liabilities, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2024 and 2023 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

December 31, 2024				
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2 %	\$ 666	\$ 537	\$ (4,151)	\$ (8,866)
1	333	268	(2,182)	(4,828)
(1)	(333)	(252)	2,082	5,831
(2)	(666)	(503)	4,311	12,935
December 31, 2023				
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	\$ 688	\$ 393	\$ (3,642)	\$ (8,142)
1	344	196	(1,871)	(4,444)
(1)	(344)	(180)	1,954	5,391
(2)	(688)	(360)	3,964	11,992

Note: The impact of hypothetical changes in interest rates may not reflect the full 100 or 200 basis point change on interest income and interest expense or on the fair value of financial assets and liabilities as the rates are assumed to not fall below zero.

As of December 31, 2024, we had \$4.9 billion of investments in equity securities, primarily consisting of venture investments and employee savings plan related investments.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the “Company”) as of December 31, 2024 and 2023, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2024, and the related notes (collectively referred to as the “financial statements”). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2024 and 2023, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2024, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company’s internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 27, 2025 expressed an unqualified opinion on the Company’s internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company’s management. Our responsibility is to express an opinion on the Company’s financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current-period audit of the financial statements that was communicated or required to be communicated to the Audit and Finance Committee and that (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Medical Care Services Incurred but not Reported (IBNR) - Refer to Notes 2 and 7 to the financial statements.

Critical Audit Matter Description

Medical costs payable includes estimates of the Company’s obligations for medical care services rendered on behalf of insured consumers, for which claims have either not yet been received or processed. The Company develops estimates for medical care services incurred but not reported (IBNR) using an actuarial model that requires management to exercise certain judgments in developing its estimates. Judgments made by management include medical cost per member per month trend factors and completion factors, which include assumptions over the time from date of service to claim receipt, the impact of actual care activity, and processing cycles.

We identified medical care services IBNR as a critical audit matter because it requires significant management assumptions in estimating the liability. This required complex auditor judgment, and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management’s methods, assumptions, and judgments in developing estimates for medical care services IBNR.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to medical care services IBNR included the following, among others:

- We tested the effectiveness of controls over management’s estimate of the IBNR for these services, including controls over the judgments in both the completion factors and the medical cost per member per month trend factors, as well as controls over the claims and membership data used in the estimation process.
- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.
- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate IBNR for these services by:
 - Performing an overlay of the historical claims data used in management’s current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in prior periods.
 - Developing an independent estimate of the IBNR for these services and comparing our estimate to management’s estimate.
 - Performing a retrospective review comparing management’s prior year estimate of IBNR to claims processed in 2024 with dates of service in 2023 or prior.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

February 27, 2025

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2024	December 31, 2023
Assets		
Current assets:		
Cash and cash equivalents	\$ 25,312	\$ 25,427
Short-term investments	3,801	4,201
Accounts receivable, net of allowances of \$985 and \$1,000	22,365	21,276
Other current receivables, net of allowances of \$2,864 and \$2,084	26,089	17,694
Assets under management	—	3,755
Prepaid expenses and other current assets	8,212	6,084
Total current assets	85,779	78,437
Long-term investments	52,354	47,609
Property, equipment and capitalized software, net of accumulated depreciation and amortization of \$6,971 and \$7,039	10,553	11,450
Goodwill	106,734	103,732
Other intangible assets, net of accumulated amortization of \$8,350 and \$7,279	23,268	15,194
Other assets	19,590	17,298
Total assets	\$ 298,278	\$ 273,720
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	\$ 34,224	\$ 32,395
Accounts payable and accrued liabilities	34,337	31,958
Short-term borrowings and current maturities of long-term debt	4,545	4,274
Unearned revenues	3,317	3,355
Other current liabilities	27,346	27,072
Total current liabilities	103,769	99,054
Long-term debt, less current maturities	72,359	58,263
Deferred income taxes	3,620	3,021
Other liabilities	15,939	14,463
Total liabilities	195,687	174,801
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	4,323	4,498
Equity:		
Preferred stock, \$0.001 par value - 10 shares authorized; no shares issued or outstanding ..	—	—
Common stock, \$0.01 par value - 3,000 shares authorized; 915 and 924 issued and outstanding	9	9
Retained earnings	96,036	95,774
Accumulated other comprehensive loss	(3,387)	(7,027)
Nonredeemable noncontrolling interests	5,610	5,665
Total equity	98,268	94,421
Total liabilities, redeemable noncontrolling interests and equity	\$ 298,278	\$ 273,720

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31,		
	2024	2023	2022
Revenues:			
Premiums	\$ 308,810	\$ 290,827	\$ 257,157
Products	50,226	42,583	37,424
Services	36,040	34,123	27,551
Investment and other income	5,202	4,089	2,030
Total revenues	400,278	371,622	324,162
Operating costs:			
Medical costs	264,185	241,894	210,842
Operating costs	53,013	54,628	47,782
Cost of products sold	46,694	38,770	33,703
Depreciation and amortization	4,099	3,972	3,400
Total operating costs	367,991	339,264	295,727
Earnings from operations	32,287	32,358	28,435
Interest expense	(3,906)	(3,246)	(2,092)
Loss on sale of subsidiary and subsidiaries held for sale	(8,310)	—	—
Earnings before income taxes	20,071	29,112	26,343
Provision for income taxes	(4,829)	(5,968)	(5,704)
Net earnings	15,242	23,144	20,639
Earnings attributable to noncontrolling interests	(837)	(763)	(519)
Net earnings attributable to UnitedHealth Group common shareholders	<u>\$ 14,405</u>	<u>\$ 22,381</u>	<u>\$ 20,120</u>
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	<u>\$ 15.64</u>	<u>\$ 24.12</u>	<u>\$ 21.47</u>
Diluted	<u>\$ 15.51</u>	<u>\$ 23.86</u>	<u>\$ 21.18</u>
Basic weighted-average number of common shares outstanding	921	928	937
Dilutive effect of common share equivalents	8	10	13
Diluted weighted-average number of common shares outstanding	<u>929</u>	<u>938</u>	<u>950</u>
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	6	6	3

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31,		
	2024	2023	2022
Net earnings	<u>\$ 15,242</u>	<u>\$ 23,144</u>	<u>\$ 20,639</u>
Other comprehensive income (loss):			
Gross unrealized gains (losses) on investment securities during the period ...	29	1,139	(4,292)
Income tax effect	(7)	(263)	984
Total unrealized gains (losses), net of tax	<u>22</u>	<u>876</u>	<u>(3,308)</u>
Gross reclassification adjustment for net realized (gains) losses included in net earnings	(369)	(90)	139
Income tax effect	92	21	(32)
Total reclassification adjustment, net of tax	<u>(277)</u>	<u>(69)</u>	<u>107</u>
Foreign currency translation (losses) gains	(319)	559	192
Reclassification adjustment for translation losses included in net earnings	4,214	—	—
Total foreign currency translation gains	<u>3,895</u>	<u>559</u>	<u>192</u>
Other comprehensive income (loss)	<u>3,640</u>	<u>1,366</u>	<u>(3,009)</u>
Comprehensive income	18,882	24,510	17,630
Comprehensive income attributable to noncontrolling interests	<u>(837)</u>	<u>(763)</u>	<u>(519)</u>
Comprehensive income attributable to UnitedHealth Group common shareholders	<u><u>\$ 18,045</u></u>	<u><u>\$ 23,747</u></u>	<u><u>\$ 17,111</u></u>

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions, except per share data)	Common Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)		Nonredeemable Noncontrolling Interests	Total Equity
	Shares	Amount			Net Unrealized Gains (Losses) on Investments	Foreign Currency Translation (Losses) Gains		
Balance at January 1, 2022	941	\$ 10	\$ —	\$ 77,134	\$ 423	\$ (5,807)	\$ 3,285	\$ 75,045
Net earnings				20,120			406	20,526
Other comprehensive (loss) income					(3,201)	192		(3,009)
Issuances of common stock, and related tax effects	7	—	903					903
Share-based compensation			875					875
Common share repurchases	(14)	(1)	(1,892)	(5,107)				(7,000)
Cash dividends paid on common shares (\$6.40 per share)				(5,991)				(5,991)
Redeemable noncontrolling interests fair value and other adjustments			114					114
Acquisition and other adjustments of nonredeemable noncontrolling interests							374	374
Distributions to nonredeemable noncontrolling interests							(387)	(387)
Balance at December 31, 2022	934	9	—	86,156	(2,778)	(5,615)	3,678	81,450
Net earnings				22,381			575	22,956
Other comprehensive income					807	559		1,366
Issuances of common stock, and related tax effects	6	—	1,231					1,231
Share-based compensation			1,027					1,027
Common share repurchases	(16)	—	(2,057)	(6,002)				(8,059)
Cash dividends paid on common shares (\$7.29 per share)				(6,761)				(6,761)
Redeemable noncontrolling interests fair value and other adjustments			(201)					(201)
Acquisition and other adjustments of nonredeemable noncontrolling interests							1,928	1,928
Distributions to nonredeemable noncontrolling interests							(516)	(516)
Balance at December 31, 2023	924	9	—	95,774	(1,971)	(5,056)	5,665	94,421
Net earnings				14,405			663	15,068
Other comprehensive (loss) income					(255)	3,895		3,640
Issuances of common stock, and related tax effects	8	—	1,485					1,485
Share-based compensation			963					963
Common share repurchases	(17)	—	(2,395)	(6,610)				(9,005)
Cash dividends paid on common shares (\$8.18 per share)				(7,533)				(7,533)
Redeemable noncontrolling interests fair value and other adjustments			(53)					(53)
Acquisition and other adjustments of nonredeemable noncontrolling interests							26	26
Distributions to nonredeemable noncontrolling interests							(744)	(744)
Balance at December 31, 2024	915	\$ 9	\$ —	\$ 96,036	\$ (2,226)	\$ (1,161)	\$ 5,610	\$ 98,268

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31,		
	2024	2023	2022
Operating activities			
Net earnings	\$ 15,242	\$ 23,144	\$ 20,639
Noncash items:			
Depreciation and amortization	4,099	3,972	3,400
Deferred income taxes	(296)	(245)	(673)
Share-based compensation	1,018	1,059	925
Loss on sale of subsidiary and subsidiaries held for sale	8,310	—	—
Gains on dispositions and other strategic transactions	(3,333)	(489)	(588)
Other, net	(28)	(16)	257
Net change in other operating items, net of effects from acquisitions and dispositions:			
Accounts receivable	(1,437)	(3,114)	(2,523)
Other assets	(4,140)	(2,444)	(1,374)
Medical costs payable	2,503	3,482	4,053
Accounts payable and other liabilities	2,463	3,516	1,964
Unearned revenues	(197)	203	126
Cash flows from operating activities	24,204	29,068	26,206
Investing activities			
Purchases of investments	(27,308)	(18,314)	(18,825)
Sales of investments	18,514	7,307	5,907
Maturities of investments	9,319	9,230	6,081
Cash paid for acquisitions and other transactions, net of cash assumed	(13,408)	(10,136)	(21,458)
Purchases of property, equipment and capitalized software	(3,499)	(3,386)	(2,802)
Loans to care providers - cyberattack	(9,033)	—	—
Repayments of care provider loans - cyberattack	4,514	—	—
Cash received from dispositions and other strategic transactions, net	2,041	685	3,414
Other, net	(1,667)	(960)	(793)
Cash flows used for investing activities	(20,527)	(15,574)	(28,476)
Financing activities			
Common share repurchases	(9,000)	(8,000)	(7,000)
Cash dividends paid	(7,533)	(6,761)	(5,991)
Proceeds from common stock issuances	1,846	1,353	1,253
Repayments of long-term debt	(3,000)	(2,125)	(3,015)
(Repayments of) proceeds from short-term borrowings, net	(151)	11	732
Proceeds from issuance of long-term debt	17,811	6,394	14,819
Customer funds administered	(1,560)	(521)	5,548
Purchases of redeemable noncontrolling interests	(280)	(730)	(176)
Other, net	(1,645)	(1,150)	(1,944)
Cash flows (used for) from financing activities	(3,512)	(11,529)	4,226
Effect of exchange rate changes on cash and cash equivalents	(61)	97	34
Increase in cash and cash equivalents, including cash within businesses held for sale	104	2,062	1,990
Less: cash within businesses held for sale	(219)	—	—
Net (decrease) increase in cash and cash equivalents	(115)	2,062	1,990
Cash and cash equivalents, beginning of period	25,427	23,365	21,375
Cash and cash equivalents, end of period	\$ 25,312	\$ 25,427	\$ 23,365
Supplemental cash flow disclosures			
Cash paid for interest	\$ 3,594	\$ 3,035	\$ 1,945
Cash paid for income taxes	4,620	6,078	5,222

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, “UnitedHealth Group” and “the Company”) is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. The Company’s two distinct, yet complementary businesses — Optum and UnitedHealthcare — are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations the Company is privileged to serve.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company’s best estimates and judgments. The Company’s most significant estimates relate to estimates and judgments for medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers’ health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company’s customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios (MLRs) as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, falling below certain targets are required to rebate ratable portions of their premiums annually. Commercial premiums within the Company’s individual and small group markets are also subject to the ACA risk adjustment program. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans’ Star rating. Certain of the Company’s Medicaid business is also subject to state minimum MLR rebates.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues for certain value-based arrangements at its Optum Health care delivery businesses. Under these value-based arrangements, the Company enters into agreements with health plans to stand ready to deliver, integrate, direct and control certain health care services for patients. In exchange, the Company receives a premium that is typically paid on a per-patient per-month basis. The Company considers these value-based arrangements to represent a single performance obligation where premium revenues are recognized in the period in which health care services are made available.

The Company’s Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS’ risk adjustment payment methodology. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis and encounter data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the data submitted and expected to be submitted to CMS. Risk adjustment data for the Company’s plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's Optum Rx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and community health pharmacies. Product revenues include the cost of pharmaceuticals (net of rebates), a negotiated dispensing fee and customer co-payments. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, product revenues are reported on a gross basis.

Services revenue includes a number of services and products sold through Optum. Optum Health's service revenues include net patient service revenues recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, Optum Health charges fees and earns investment income on managed funds. Optum Insight provides software and information products, advisory consulting arrangements and managed services outsourcing contracts, which may be delivered over several years. Optum Insight revenues are generally recognized over time and measured for each period based on the progress to date as services are performed or made available to customers.

Services revenue also consists of fees derived from services performed for customers who self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives a monthly fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

As of December 31, 2024 and 2023, accounts receivables related to products and services were \$9.9 billion and \$8.6 billion, respectively. In 2024 and 2023, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2024 or 2023.

For the years ended December 31, 2024, 2023 and 2022, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

As of December 31, 2024, revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts having an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, was \$12.7 billion, of which approximately half is expected to be recognized in the next three years.

See Note 14 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2024.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services rendered on behalf of consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims which have not been received or fully processed, using an actuarial process consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, care activity and other medical cost trends, membership volume and

demographics, the introduction of new technologies, benefit plan changes and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery, specialty and community pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to unaffiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those unaffiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments having an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments. Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments are measured at fair value, with certain exceptions where the Company has elected to measure investments with unobservable inputs at cost, subject to fair value adjustments upon an impairment or a transaction of the same or similar security. Changes in fair value of equity investments are recognized in net earnings.

The Company excludes unrealized gains and losses on available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an available-for-sale debt security for credit-related impairment by considering the present value of expected cash flows relative to a security's amortized cost, the extent to which fair value is less than amortized cost, the financial condition and near-term prospects of the issuer and specific events or circumstances which may influence the operations of the issuer. Credit-related impairments are recorded as an allowance, with an offset to investment and other income. Non-credit related impairments are recorded through other comprehensive income. If the Company intends to sell an impaired security, or will likely be required to sell a security before recovery of the entire amortized cost, the entire impairment is included in net earnings.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality.

Assets Under Management

In July 2024, the Company amended its Medicare Supplement Program with a membership organization (the Medicare Supplement Program). The amendments provide the Company the right to use a trade name and other intellectual property in marketing efforts for Medicare Supplement offerings. Amounts previously reported as assets under management are now included within the Company's Consolidated Balance Sheet based upon their classification.

For periods prior to the amended Medicare Supplement Program, the Company excluded the effects of certain balance sheet amounts in its Consolidated Statements of Cash Flows, while these effects are included for periods after the amendments.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, loans to care providers in response to the Change Healthcare cyberattack, accrued interest and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and unaffiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2024 and 2023, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to \$12.5 billion and \$11.0 billion, respectively.

Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets included pharmaceutical drug and supplies inventory of \$3.8 billion and \$2.8 billion as of December 31, 2024 and 2023, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Operating Leases

The Company leases facilities and equipment under long-term operating leases which are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use (ROU) assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period closely matching the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Consolidated Balance Sheet.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs impairment tests. The Company may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates a goodwill impairment is more likely than not, we perform additional quantitative analyses. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital levels and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

There was no impairment of goodwill during the years ended December 31, 2024, 2023 and 2022.

Intangible Assets

The Company's finite-lived intangible assets are subject to impairment tests when events or circumstances indicate an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the years ended December 31, 2024, 2023 and 2022.

Other Current Liabilities

Other current liabilities include health savings account deposits (\$13.7 billion and \$13.5 billion as of December 31, 2024 and 2023, respectively), accruals for premium rebates payable, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside of the Company's control are classified as temporary equity. These interests primarily relate to put options on unowned shares, which are typically redeemable at fair value after a certain time period. The Company accretes changes in the redemption value to the earliest redemption date utilizing the interest method. If all interests were currently redeemable, the difference between the carrying value and the estimated redemption value is not material. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2024 and 2023:

(in millions)	2024	2023
Redeemable noncontrolling interests, beginning of period	\$ 4,498	\$ 4,897
Net earnings	174	188
Acquisitions	33	122
Redemptions	(280)	(730)
Distributions	(125)	(144)
Fair value and other adjustments	23	165
Redeemable noncontrolling interests, end of period	<u>\$ 4,323</u>	<u>\$ 4,498</u>

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over four years, and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 90% of the market price of the Company's common stock at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2024				
Debt securities - available-for-sale:				
U.S. government and agency obligations	\$ 4,600	\$ 1	\$ (274)	\$ 4,327
State and municipal obligations	7,357	2	(375)	6,984
Corporate obligations	24,391	56	(1,140)	23,307
U.S. agency mortgage-backed securities	10,577	1	(994)	9,584
Non-U.S. agency mortgage-backed securities	2,890	2	(175)	2,717
Total debt securities - available-for-sale	<u>49,815</u>	<u>62</u>	<u>(2,958)</u>	<u>46,919</u>
Debt securities - held-to-maturity:				
U.S. government and agency obligations	444	—	(2)	442
State and municipal obligations	28	—	(2)	26
Corporate obligations	40	—	—	40
Total debt securities - held-to-maturity	<u>512</u>	<u>—</u>	<u>(4)</u>	<u>508</u>
Total debt securities	<u>\$ 50,327</u>	<u>\$ 62</u>	<u>\$ (2,962)</u>	<u>\$ 47,427</u>
December 31, 2023				
Debt securities - available-for-sale:				
U.S. government and agency obligations	\$ 4,674	\$ 3	\$ (234)	\$ 4,443
State and municipal obligations	7,636	39	(322)	7,353
Corporate obligations	23,136	67	(1,186)	22,017
U.S. agency mortgage-backed securities	8,982	22	(708)	8,296
Non-U.S. agency mortgage-backed securities	3,023	3	(240)	2,786
Total debt securities - available-for-sale	<u>47,451</u>	<u>134</u>	<u>(2,690)</u>	<u>44,895</u>
Debt securities - held-to-maturity:				
U.S. government and agency obligations	506	1	(6)	501
State and municipal obligations	28	—	(2)	26
Corporate obligations	69	—	—	69
Total debt securities - held-to-maturity	<u>603</u>	<u>1</u>	<u>(8)</u>	<u>596</u>
Total debt securities	<u>\$ 48,054</u>	<u>\$ 135</u>	<u>\$ (2,698)</u>	<u>\$ 45,491</u>

Nearly all of the Company's investments in mortgage-backed securities were rated "Double A" or better as of December 31, 2024.

The Company held \$4.9 billion of equity securities as of December 31, 2024 and 2023. The Company's investments in equity securities primarily consist of venture investments and employee savings plan related investments. Additionally, the Company's investments included \$3.8 billion and \$1.4 billion of equity method investments primarily in operating businesses in the health care sector, as of December 31, 2024 and 2023, respectively. The allowance for credit losses on held-to-maturity securities as of December 31, 2024 and 2023 was not material.

The amortized cost and fair value of debt securities as of December 31, 2024, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	\$ 3,952	\$ 3,932	\$ 320	\$ 319
Due after one year through five years	14,845	14,384	161	161
Due after five years through ten years	12,110	11,213	14	13
Due after ten years	5,441	5,089	17	15
U.S. agency mortgage-backed securities	10,577	9,584	—	—
Non-U.S. agency mortgage-backed securities	2,890	2,717	—	—
Total debt securities	<u>\$ 49,815</u>	<u>\$ 46,919</u>	<u>\$ 512</u>	<u>\$ 508</u>

The fair value of available-for-sale debt securities with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2024						
U.S. government and agency obligations	\$ 1,475	\$ (51)	\$ 2,152	\$ (223)	\$ 3,627	\$ (274)
State and municipal obligations	2,593	(58)	4,085	(317)	6,678	(375)
Corporate obligations	7,402	(213)	11,449	(927)	18,851	(1,140)
U.S. agency mortgage-backed securities	4,791	(191)	4,674	(803)	9,465	(994)
Non-U.S. agency mortgage-backed securities	416	(5)	1,863	(170)	2,279	(175)
Total debt securities - available-for-sale	<u>\$ 16,677</u>	<u>\$ (518)</u>	<u>\$ 24,223</u>	<u>\$ (2,440)</u>	<u>\$ 40,900</u>	<u>\$ (2,958)</u>
December 31, 2023						
U.S. government and agency obligations	\$ 1,270	\$ (7)	\$ 2,077	\$ (227)	\$ 3,347	\$ (234)
State and municipal obligations	907	(7)	4,063	(315)	4,970	(322)
Corporate obligations	1,826	(17)	14,696	(1,169)	16,522	(1,186)
U.S. agency mortgage-backed securities	1,337	(12)	5,069	(696)	6,406	(708)
Non-U.S. agency mortgage-backed securities	279	(6)	2,202	(234)	2,481	(240)
Total debt securities - available-for-sale	<u>\$ 5,619</u>	<u>\$ (49)</u>	<u>\$ 28,107</u>	<u>\$ (2,641)</u>	<u>\$ 33,726</u>	<u>\$ (2,690)</u>

The Company's unrealized losses from all securities as of December 31, 2024 were generated from approximately 34,000 positions out of a total of 43,000 positions. The Company believes it will timely collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities which impacted the Company's assessment on collectibility of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers, noting no significant credit deterioration since purchase. As of December 31, 2024, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary. The allowance for credit losses on available-for-sale debt securities as of December 31, 2024 and 2023 was not material.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input which is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs corroborated by other observable market data.

Level 3 — Unobservable inputs cannot be corroborated by observable market data.

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2024 or 2023.

Nonfinancial assets and liabilities or financial assets and liabilities measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. For the years ended December 31, 2024, 2023 and 2022, the Company recognized \$710 million, \$276 million and \$211 million respectively, of unrealized gains in investment and other income related to fair value adjustments on equity securities primarily in the Company's venture portfolio, based upon transactions of the same or similar security. The assets and liabilities within our South American operations held for sale as of December 31, 2024 were measured at the lower of carrying value or fair value less cost to sell. Fair value is measured based upon unobservable amounts, such as estimated selling price derived from Company-specific information and market conditions. There were no other significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2024, 2023 or 2022.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments which do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt securities and equity securities reported at fair value on a recurring basis are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs currently observable in the markets for similar securities. Inputs often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities which do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities reported at fair value on a recurring basis are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds, which are not a significant portion of our investments, are estimated using valuation techniques relying heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on such understanding.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2024				
Cash and cash equivalents	\$ 25,248	\$ 64	\$ —	\$ 25,312
Debt securities - available-for-sale:				
U.S. government and agency obligations	4,194	133	—	4,327
State and municipal obligations	—	6,984	—	6,984
Corporate obligations	29	22,841	437	23,307
U.S. agency mortgage-backed securities	—	9,584	—	9,584
Non-U.S. agency mortgage-backed securities	—	2,717	—	2,717
Total debt securities - available-for-sale	4,223	42,259	437	46,919
Equity securities	1,859	24	65	1,948
Total assets at fair value	\$ 31,330	\$ 42,347	\$ 502	\$ 74,179
Percentage of total assets at fair value	42 %	57 %	1 %	100 %
December 31, 2023				
Cash and cash equivalents	\$ 25,345	\$ 82	\$ —	\$ 25,427
Debt securities - available-for-sale:				
U.S. government and agency obligations	4,167	276	—	4,443
State and municipal obligations	—	7,353	—	7,353
Corporate obligations	15	21,800	202	22,017
U.S. agency mortgage-backed securities	—	8,296	—	8,296
Non-U.S. agency mortgage-backed securities	—	2,786	—	2,786
Total debt securities - available-for-sale	4,182	40,511	202	44,895
Equity securities	2,468	16	69	2,553
Assets under management	1,505	2,140	110	3,755
Total assets at fair value	\$ 33,500	\$ 42,749	\$ 381	\$ 76,630
Percentage of total assets at fair value	44 %	55 %	1 %	100 %

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2024					
Debt securities - held-to-maturity	\$ 482	\$ 26	\$ —	\$ 508	\$ 512
Long-term debt and other financing obligations	\$ —	\$ 70,565	\$ —	\$ 70,565	\$ 75,604
December 31, 2023					
Debt securities - held-to-maturity	\$ 524	\$ 72	\$ —	\$ 596	\$ 603
Long-term debt and other financing obligations	\$ —	\$ 59,851	\$ —	\$ 59,851	\$ 61,449

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2024	December 31, 2023
Land and improvements	\$ 364	\$ 712
Buildings and improvements	4,215	5,573
Computer equipment	2,267	2,007
Furniture and fixtures	1,694	2,375
Less accumulated depreciation	(3,645)	(4,210)
Property and equipment, net	4,895	6,457
Capitalized software	8,984	7,822
Less accumulated amortization	(3,326)	(2,829)
Capitalized software, net	5,658	4,993
Total property, equipment and capitalized software, net	\$ 10,553	\$ 11,450

Depreciation expense for property and equipment for the years ended December 31, 2024, 2023 and 2022 was \$1.0 billion, \$1.1 billion, and \$1.1 billion, respectively. Amortization expense for capitalized software for the years ended December 31, 2024, 2023 and 2022 was \$1.4 billion, \$1.2 billion and \$1.0 billion, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	Optum Health	Optum Insight	Optum Rx	Consolidated
Balance at January 1, 2023	\$ 27,395	\$ 29,238	\$ 17,244	\$ 19,475	\$ 93,352
Acquisitions	296	8,023	1,802	—	10,121
Foreign currency effects and other adjustments, net	187	(182)	261	(7)	259
Balance at December 31, 2023	27,878	37,079	19,307	19,468	103,732
Acquisitions	—	2,071	—	2,305	4,376
Dispositions, foreign currency effects and other adjustments, net	(717)	(324)	(327)	(6)	(1,374)
Balance at December 31, 2024	\$ 27,161	\$ 38,826	\$ 18,980	\$ 21,767	\$ 106,734

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2024			December 31, 2023		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	\$ 17,190	\$ (6,675)	\$ 10,515	\$ 16,636	\$ (5,909)	\$ 10,727
Trademarks and technology	2,917	(1,284)	1,633	2,508	(958)	1,550
Trade names, trademarks, operating licenses and certificates and other indefinite-lived	10,454	—	10,454	2,116	—	2,116
Other	1,057	(391)	666	1,213	(412)	801
Total	\$ 31,618	\$ (8,350)	\$ 23,268	\$ 22,473	\$ (7,279)	\$ 15,194

The fair values and weighted-average useful lives assigned to intangible assets as a result of transactions completed during years ended:

(in millions, except years)	2024		2023	
	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	\$ 1,258	12 years	\$ 477	12 years
Trademarks and technology	527	6 years	226	5 years
Other	22	8 years	44	9 years
Total finite-lived	<u>\$ 1,807</u>	10 years	<u>\$ 747</u>	9 years
Total indefinite-lived - trade names, trademarks, operating licenses and certificates and other	8,795		1,427	
Total intangible assets	<u>\$ 10,602</u>		<u>\$ 2,174</u>	

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2025	\$ 1,655
2026	1,503
2027	1,424
2028	1,344
2029	1,211

Amortization expense relating to intangible assets for the years ended December 31, 2024, 2023 and 2022 was \$1.7 billion, \$1.6 billion and \$1.3 billion, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2024	2023	2022
Medical costs payable, beginning of period	\$ 32,395	\$ 29,056	\$ 24,483
Acquisitions (dispositions), net	(755)	1	308
Reported medical costs:			
Current year	264,885	242,734	211,252
Prior years	(700)	(840)	(410)
Total reported medical costs	<u>264,185</u>	<u>241,894</u>	<u>210,842</u>
Medical payments:			
Payments for current year	(231,890)	(211,380)	(184,049)
Payments for prior years	(29,532)	(27,176)	(22,528)
Total medical payments	<u>(261,422)</u>	<u>(238,556)</u>	<u>(206,577)</u>
Less: medical costs payable included within businesses held for sale	(179)	—	—
Medical costs payable, end of period	<u>\$ 34,224</u>	<u>\$ 32,395</u>	<u>\$ 29,056</u>

For the years ended December 31, 2024, 2023 and 2022, prior years' medical cost reserve development included no individual factors that were significant. Medical costs payable included IBNR of \$23.7 billion and \$22.3 billion at December 31, 2024 and 2023, respectively. Substantially all of the IBNR balance as of December 31, 2024 relates to the current year.

The following is information about incurred and paid medical cost development as of December 31, 2024:

(in millions) Year	Net Incurred Medical Costs	
	For the Years Ended December 31,	
	2023	2024
2023	\$ 242,734	\$ 242,156
2024		264,885
Total		\$ 507,041

(in millions) Year	Net Cumulative Medical Payments	
	For the Years Ended December 31,	
	2023	2024
2023	\$ (211,380)	\$ (240,112)
2024		(231,890)
Total		(472,002)
Net remaining outstanding liabilities prior to 2023		119
Acquisitions (dispositions), net		(755)
Medical costs payable included within businesses held for sale		(179)
Total medical costs payable		\$ 34,224

8. Short-Term Borrowings and Long-Term Debt

Short-term borrowings and senior unsecured long-term debt consisted of commercial paper and notes as follows:

(in millions, except percentages)	Carrying Value as of December 31,		(continued)	Carrying Value as of December 31,	
	2024	2023		2024	2023
Commercial paper	\$ 1,300	\$ 1,088	\$1,000 4.625%, Jul 2035	971	1,014
\$750 3.5%, Feb 2024	—	750	\$850 5.8%, Mar 2036	838	838
\$1,000 0.55%, May 2024	—	999	\$500 6.5%, Jun 2037	492	491
\$750 2.375%, Aug 2024	—	750	\$650 6.625%, Nov 2037	641	640
\$500 5%, Oct 2024	—	499	\$1,100 6.875%, Feb 2038	1,079	1,078
\$2,000 3.75%, Jul 2025	1,999	1,997	\$1,250 3.5%, Aug 2039	1,243	1,242
\$750 5.15%, Oct 2025	749	748	\$1,000 2.75%, May 2040	970	968
\$300 3.7%, Dec 2025	300	299	\$300 5.7%, Oct 2040	296	296
\$500 1.25%, Jan 2026	499	498	\$350 5.95%, Feb 2041	346	346
\$1,000 3.1%, Mar 2026	999	998	\$1,500 3.05%, May 2041	1,485	1,484
\$1,000 1.15%, May 2026	953	924	\$600 4.625%, Nov 2041	590	590
\$500 floating rate, Jul 2026	499	—	\$502 4.375%, Mar 2042	487	486
\$650 4.75%, Jul 2026	648	—	\$625 3.95%, Oct 2042	610	609
\$750 3.45%, Jan 2027	749	748	\$750 4.25%, Mar 2043	737	736
\$500 4.6%, Apr 2027	496	—	\$1,500 5.5%, Jul 2044	1,475	—
\$625 3.375%, Apr 2027	623	622	\$2,000 4.75%, Jul 2045	1,976	1,975
\$600 3.7%, May 2027	598	598	\$750 4.2%, Jan 2047	739	739
\$950 2.95%, Oct 2027	946	944	\$725 4.25%, Apr 2047	718	718
\$1,000 5.25%, Feb 2028	998	1,011	\$950 3.75%, Oct 2047	935	935
\$1,150 3.85%, Jun 2028	1,147	1,146	\$1,350 4.25%, Jun 2048	1,332	1,331
\$850 3.875%, Dec 2028	847	846	\$1,100 4.45%, Dec 2048	1,087	1,087
\$1,250 4.25%, Jan 2029	1,221	1,238	\$1,250 3.7%, Aug 2049	1,237	1,236
\$400 4.7%, Apr 2029	398	—	\$1,250 2.9%, May 2050	1,212	1,211
\$900 4%, May 2029	854	862	\$2,000 3.25%, May 2051	1,972	1,972
\$1,000 2.875%, Aug 2029	902	908	\$2,000 4.75%, May 2052	1,966	1,966
\$1,250 4.8%, Jan 2030	1,225	—	\$2,000 5.875%, Feb 2053	1,968	1,968
\$1,250 5.3%, Feb 2030	1,243	1,275	\$2,000 5.05%, Apr 2053	1,969	1,969
\$1,250 2%, May 2030	1,240	1,238	\$1,750 5.375%, Apr 2054	1,729	—
\$1,000 4.9%, Apr 2031	982	—	\$2,750 5.625%, Jul 2054	2,724	—
\$1,500 2.3%, May 2031	1,271	1,290	\$1,250 3.875%, Aug 2059	1,229	1,229
\$1,500 4.95%, Jan 2032	1,489	—	\$1,000 3.125%, May 2060	967	966
\$1,500 4.2%, May 2032	1,372	1,412	\$1,000 4.95%, May 2062	981	981
\$2,000 5.35%, Feb 2033	1,966	2,046	\$1,500 6.05%, Feb 2063	1,466	1,466
\$1,500 4.5%, Apr 2033	1,410	1,463	\$1,750 5.2%, Apr 2063	1,710	1,709
\$1,250 5%, Apr 2034	1,214	—	\$1,100 5.5%, Apr 2064	1,085	—
\$2,000 5.15%, Jul 2034	1,959	—	\$1,850 5.75%, Jul 2064	1,822	—
			Total short-term borrowings and long-term debt	<u>\$ 76,180</u>	<u>\$ 61,473</u>

The Company's long-term debt obligations also included \$0.7 billion and \$1.1 billion of other financing obligations, of which \$197 million and \$188 million were current as of December 31, 2024 and 2023, respectively.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2025	\$ 4,548
2026	3,756
2027	3,531
2028	3,106
2029	3,656
Thereafter	59,908

Short-Term Borrowings

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2024, the Company's outstanding commercial paper had a weighted-average annual interest rate of 4.4%.

The Company has \$7.0 billion five-year, \$7.0 billion three-year and \$7.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2029, December 2027 and December 2025, respectively. These facilities provide full liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2024, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on one-month term Secured Overnight Financing Rate (SOFR) plus a SOFR Adjustment of 10 basis points plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2024, annual interest rates would have ranged from 4.9% to 7.5%.

Debt Covenants

As of December 31, 2024, the Company was in compliance with the various covenants under its bank credit facilities.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses.

The components of income before income taxes, based upon tax jurisdiction, for the years ended December 31 are as follows:

(in millions)	2024	2023	2022
Income before income taxes:			
Domestic	\$ 28,264	\$ 29,210	\$ 26,685
Foreign	(8,193)	(98)	(342)
Total income before income taxes	<u>\$ 20,071</u>	<u>\$ 29,112</u>	<u>\$ 26,343</u>

The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2024	2023	2022
Current Provision:			
Federal	\$ 3,453	\$ 4,418	\$ 4,842
State and local	416	716	855
Foreign	1,256	1,079	680
Total current provision	5,125	6,213	6,377
Deferred benefit	(296)	(245)	(673)
Total provision for income taxes	<u>\$ 4,829</u>	<u>\$ 5,968</u>	<u>\$ 5,704</u>

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2024		2023		2022	
Tax provision at the U.S. federal statutory rate	\$ 4,215	21.0 %	\$ 6,114	21.0 %	\$ 5,532	21.0 %
State income taxes, net of federal benefit	343	1.7	567	2.0	621	2.4
Share-based awards - excess tax benefit	(96)	(0.5)	(75)	(0.3)	(110)	(0.4)
Non-deductible compensation	171	0.9	174	0.6	150	0.6
Foreign rate differential	(369)	(1.8)	(442)	(1.5)	(265)	(1.0)
Tax effect of dispositions and other strategic transactions	1,215	6.1	(29)	(0.1)	(215)	(0.8)
Other, net	(650)	(3.3)	(341)	(1.2)	(9)	(0.1)
Provision for income taxes	<u>\$ 4,829</u>	<u>24.1 %</u>	<u>\$ 5,968</u>	<u>20.5 %</u>	<u>\$ 5,704</u>	<u>21.7 %</u>

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2024	2023
Deferred income tax assets:		
Accrued expenses and allowances	\$ 1,055	\$ 754
U.S. federal and state net operating loss carryforwards	442	417
Share-based compensation	189	173
Nondeductible liabilities	343	329
Non-U.S. tax loss carryforwards	21	1,061
Lease liability	846	930
Net unrealized losses on investments	669	586
Other-domestic	597	327
Other-non-U.S.	59	484
Subtotal	<u>4,221</u>	<u>5,061</u>
Less: valuation allowances	<u>(397)</u>	<u>(366)</u>
Total deferred income tax assets	<u>3,824</u>	<u>4,695</u>
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(4,479)	(3,712)
Non-U.S. goodwill and intangible assets	(82)	(731)
Capitalized software	(288)	(415)
Depreciation and amortization	(400)	(371)
Prepaid expenses	(374)	(326)
Outside basis in partnerships	(960)	(811)
Lease right-of-use asset	(833)	(914)
Other-non-U.S.	(28)	(436)
Total deferred income tax liabilities	<u>(7,444)</u>	<u>(7,716)</u>
Net deferred income tax liabilities	<u>\$ (3,620)</u>	<u>\$ (3,021)</u>

Valuation allowances are provided when it is considered more likely than not deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Substantially all of the federal net operating loss carryforwards have indefinite carryforward periods; state net operating loss carryforwards expire beginning in 2025 through 2044, with some having an indefinite carryforward period. Additionally, as of December 31, 2024, the Company has historical non-U.S. net operating loss carryforwards for which a deferred tax asset and valuation allowance of \$4.1 billion are not established because realization of the loss carryforwards is remote.

As of December 31, 2024, except for subsidiaries held for sale, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2024	2023	2022
Gross unrecognized tax benefits, beginning of period	\$ 3,716	\$ 3,081	\$ 2,310
Gross increases:			
Current year tax positions	578	782	586
Prior year tax positions	10	97	206
Gross decreases:			
Prior year tax positions	(121)	(212)	(21)
Statute of limitations lapses and settlements	(60)	(32)	—
Gross unrecognized tax benefits, end of period	<u>\$ 4,123</u>	<u>\$ 3,716</u>	<u>\$ 3,081</u>

The Company believes it is reasonably possible its liability for unrecognized tax benefits will decrease in the next twelve months by \$101 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies net interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2024, 2023 and 2022, the Company recognized \$210 million, \$177 million and \$64 million of net interest and penalties, respectively. The Company had \$637 million and \$430 million of accrued interest and penalties for uncertain tax positions as of December 31, 2024 and 2023, respectively. These amounts are not included in the reconciliation above. As of December 31, 2024, there were \$2.0 billion of unrecognized tax benefits which, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 through 2020 tax years are under review by the IRS under its Compliance Assurance Program. The Company is no longer subject to state income tax examinations prior to the 2015 tax year. The Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions which may be paid to their parent companies. In the United States, most of these state regulations and standards are generally consistent with model regulations established by the NAIC. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2024, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of \$9.2 billion, including \$2.6 billion of extraordinary dividends. For the year ended December 31, 2023, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of \$8.0 billion, including \$4.9 billion of extraordinary dividends.

The Company's financially regulated subsidiaries had estimated aggregate statutory capital and surplus of \$37.8 billion as of December 31, 2024. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's financially regulated subsidiaries was approximately \$20.4 billion as of December 31, 2024.

Optum Bank must meet minimum capital requirements of the FDIC under the capital adequacy rules to which it is subject. At December 31, 2024, the Company believes Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain restrictions. In June 2024, the Board of Directors amended the Company's share repurchase program to authorize the

repurchase of up to 35 million shares of its common stock, in addition to all remaining shares authorized to be repurchased under the Board's 2018 renewal of the program. The Board of Directors from time to time may further amend the share repurchase program in order to increase the authorized number of shares which may be repurchased under the program.

A summary of common share repurchases for the years ended December 31, 2024 and 2023 is as follows:

(in millions, except per share data)	Years Ended December 31,	
	2024	2023
Common share repurchases, shares.....	17	16
Common share repurchases, average price per share.....	\$ 529.85	\$ 493.79
Common share repurchases, aggregate cost.....	\$ 8,942	\$ 8,000
Board authorized shares remaining.....	33	15

Dividends

In June 2024, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of \$8.40 compared to \$7.52 per share, which the Company had paid since June 2023. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2024 dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
March 19	\$ 1.88	\$ 1,729
June 25	2.10	1,935
September 24.....	2.10	1,937
December 17	2.10	1,932

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options and restricted shares. As of December 31, 2024, the Company had 48 million shares available for future grants of share-based awards under the 2020 Stock Incentive Plan. As of December 31, 2024, there were 16 million shares of common stock available for issuance under the ESPP.

Stock Options

Stock option activity for the year ended December 31, 2024 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period.....	21	\$ 320		
Granted.....	3	522		
Exercised.....	(6)	253		
Forfeited.....	(1)	480		
Outstanding at end of period.....	17	370	5.6	\$ 2,338
Exercisable at end of period.....	10	298	4.2	2,115
Vested and expected to vest, end of period.....	17	368	5.5	2,335

Restricted Shares

Restricted share activity for the year ended December 31, 2024 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	4	\$ 449
Granted	2	523
Vested	(2)	435
Nonvested at end of period	4	489

Other Share-Based Compensation Data

(in millions, except per share amounts)	For the Years Ended December 31,		
	2024	2023	2022
Stock Options			
Weighted-average grant date fair value of shares granted, per share	\$ 138	\$ 134	\$ 116
Total intrinsic value of stock options exercised	1,886	1,325	1,419
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	523	493	483
Total fair value of restricted shares vested	690	803	760
Employee Stock Purchase Plan			
Number of shares purchased	1	1	1
Share-Based Compensation Items			
Share-based compensation expense, before tax	\$ 1,018	\$ 1,059	\$ 925
Share-based compensation expense, net of tax effects	896	937	836
Income tax benefit realized from share-based award exercises	216	231	207

(in millions, except years)	December 31, 2024
Unrecognized compensation expense related to share awards	\$ 1,099
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options were as follows:

	For the Years Ended December 31,		
	2024	2023	2022
Risk-free interest rate	3.6% - 4.4%	3.8% - 4.6%	1.9% - 4.3%
Expected volatility	25.5% - 30.7%	29.7% - 30.6%	30.6% - 30.8%
Expected dividend yield	1.4% - 1.5%	1.3% - 1.5%	1.2%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	4.6	4.6	4.7

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option exercises and forfeitures within the valuation model. The expected lives of options granted represent the periods of time the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for the years ended December 31, 2024, 2023 and 2022.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus. The deferrals are recorded within long-term investments

with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were \$2.1 billion and \$1.9 billion as of December 31, 2024 and 2023, respectively.

12. Commitments and Contingencies

Leases

Operating lease costs, including immaterial variable and short-term lease costs, were \$1.4 billion, \$1.4 billion and \$1.3 billion for the years ended December 31, 2024, 2023 and 2022, respectively. Cash payments made on the Company's operating lease liabilities were \$1.1 billion, \$1.1 billion and \$1.0 billion for the years ended December 31, 2024, 2023 and 2022, respectively, which were classified within operating activities in the Consolidated Statements of Cash Flows. As of December 31, 2024, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 9.5 years and 4.7%, respectively.

As of December 31, 2024, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2025	\$ 1,014
2026	876
2027	688
2028	568
2029	583
Thereafter	2,465
Total future minimum lease payments	6,194
Less imputed interest	(1,305)
Total	<u>\$ 4,889</u>

Other Commitments

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2024, 2023 or 2022.

Pending Acquisitions

As of December 31, 2024, the Company has entered into agreements to acquire companies in the health care sector, subject to regulatory approval and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately \$4 billion.

Legal Matters

The Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office for Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice (DOJ), the SEC, the IRS, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the

FDIC, the Consumer Financial Protection Bureau, the Defense Contract Audit Agency, the Food and Drug Administration and other governmental authorities. Similarly, the Company's international businesses are also subject to investigations, audits and reviews by applicable foreign governments and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans. On February 14, 2017, the DOJ announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome which may result from this matter given its procedural status.

13. Dispositions and Held for Sale

During the year ended December 31, 2024, the Company completed or initiated various business portfolio refinement and asset disposition activities. The Company recorded a loss of \$7.1 billion related to the sale of its Brazil operations, of which \$4.1 billion related to the impact of cumulative foreign currency translation losses previously included in accumulated other comprehensive loss, and a loss of \$1.2 billion related to the reclassification of the Company's remaining South American operations as held for sale, of which \$855 million related to the impact of cumulative foreign currency translation losses.

As these losses relate to our strategic exit of South American markets and include significant losses related to foreign currency translation effects, these losses are included within loss on sale of subsidiary and subsidiaries held for sale on the Consolidated Statement of Operations. The sales of the Company's remaining South American assets are expected to close within a year, subject to regulatory and other customary closing conditions. Assets and liabilities held for sale have been included within prepaid and other current assets and other current liabilities on the Consolidated Balance Sheet, respectively.

The assets and liabilities of the Brazil and held for sale disposal groups as of the date of the sale and as of December 31, 2024, respectively, were as follows:

(in millions)	Brazil Disposition	Businesses Held for Sale
Assets		
Cash and cash equivalents	\$ 778	\$ 219
Accounts receivable and other current assets	515	573
Long-term investments	788	41
Property, equipment and capitalized software	1,052	641
Deferred tax assets	1,035	—
Goodwill and other intangible assets	317	413
Other long-term assets	439	231
Remeasurement of assets of businesses held for sale to fair value less cost to sell ⁽¹⁾	—	(1,224)
Total assets	<u>\$ 4,924</u>	<u>\$ 894</u>
Liabilities		
Medical costs payable	\$ 701	\$ 179
Accounts payable and other current liabilities	834	338
Other long-term liabilities	136	504
Total liabilities	<u>\$ 1,671</u>	<u>\$ 1,021</u>

⁽¹⁾ Includes the effect of \$855 million of cumulative foreign currency translation losses and \$56 million of noncontrolling interests.

As a result of continued portfolio refinement, the Company sold other businesses and assets and entered into strategic transactions. These transactions resulted in total consideration received of \$3.0 billion and an additional \$1.9 billion of equity method investments related to the valuation of our retained interests in certain transactions. The carrying value for these transactions was \$1.0 billion, primarily related to goodwill. The gains from business portfolio refinement, including strategic

transactions, were recorded within operating costs in the Consolidated Statement of Operations and contributed about 80 basis points (\$3.3 billion) to the operating cost ratio, nearly half (\$1.4 billion) related to Optum Health with the remainder split between UnitedHealthcare (\$1.1 billion) and Optum Insight (\$800 million). Certain transactions also included various put and call options, which were valued at \$630 million and included in other liabilities on the Consolidated Balance Sheet. As of December 31, 2024 the total estimated future obligation under these arrangements if the Company decided or was required to repurchase these interests was up to \$3.4 billion.

14. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker (CODM), which is the Chief Executive Officer, to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes which operate in a similar regulatory environment are combined. The CODM uses consolidated expense information and segment earnings from operations to assess performance and determine allocation of resources.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State. The businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for employers and individuals. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs. UnitedHealthcare Community & State provides diversified health care benefits products and services to state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage.
- *Optum Health* focuses on care delivery, including value-based care; care management; wellness and consumer engagement and health financial services. Optum Health is building a comprehensive, connected health care delivery and engagement platform by directly providing high-quality care, helping people manage chronic and complex health needs, and proactively engaging consumers in managing their health through in-person, in-home, virtual and digital clinical platforms.
- *Optum Insight* brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations depend on Optum Insight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *Optum Rx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and community health pharmacy services, infusion, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease and drug therapy management. Optum Rx integrates pharmacy and medical care and is positioned to serve patients with complex clinical needs and consumers looking for a better digital pharmacy experience with transparent pricing.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by Optum Rx; care delivery, care management services and certain product offerings sold to UnitedHealthcare by Optum Health; and health information and technology solutions, consulting and other services sold to UnitedHealthcare by Optum Insight. These transactions are recorded at management's estimate of fair value. Transactions with affiliated customers are eliminated in consolidation. Assets and liabilities jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned so each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 40%, 40% and 38% for the years ended December 31, 2024, 2023 and 2022, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 99%, 97% and 97% of consolidated total revenues for 2024, 2023 and 2022, respectively. Long-lived fixed assets located in the United States represented approximately 92% and 82% of the total long-lived fixed assets as of December 31, 2024 and 2023, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Employer & Individual's international businesses.

The following table presents the reportable segment financial information:

		Optum						
(in millions)	UnitedHealthcare	Optum Health	Optum Insight	Optum Rx	Optum Eliminations	Optum	Corporate and Eliminations	Consolidated
2024								
Revenues - unaffiliated customers:								
Premiums	\$ 286,004	\$ 22,806	\$ —	\$ —	\$ —	\$ 22,806	\$ —	\$ 308,810
Products	—	277	174	49,775	—	50,226	—	50,226
Services	9,791	16,153	6,466	3,630	—	26,249	—	36,040
Total revenues - unaffiliated customers	295,795	39,236	6,640	53,405	—	99,281	—	395,076
Total revenues - affiliated customers	—	63,883	11,881	79,512	(4,389)	150,887	(150,887)	—
Investment and other income	2,413	2,239	236	314	—	2,789	—	5,202
Total revenues	\$ 298,208	\$ 105,358	\$ 18,757	\$ 133,231	\$ (4,389)	\$ 252,957	\$ (150,887)	\$ 400,278
Total operating costs (a)	\$ 282,624	\$ 97,588	\$ 15,660	\$ 127,395	\$ (4,389)	\$ 236,254	\$ (150,887)	\$ 367,991
Earnings from operations	\$ 15,584	\$ 7,770	\$ 3,097	\$ 5,836	\$ —	\$ 16,703	\$ —	\$ 32,287
Interest expense	—	—	—	—	—	—	(3,906)	(3,906)
Loss on sale of subsidiary and subsidiaries held for sale	(8,310)	—	—	—	—	—	—	(8,310)
Earnings before income taxes	\$ 7,274	\$ 7,770	\$ 3,097	\$ 5,836	\$ —	\$ 16,703	\$ (3,906)	\$ 20,071
Total assets	\$ 119,009	\$ 96,472	\$ 34,452	\$ 59,086	\$ —	\$ 190,010	\$ (10,741)	\$ 298,278
Purchases of property, equipment and capitalized software	781	1,008	1,291	419	—	2,718	—	3,499
Depreciation and amortization	889	1,123	1,294	793	—	3,210	—	4,099
2023								
Revenues - unaffiliated customers:								
Premiums	\$ 269,052	\$ 21,775	\$ —	\$ —	\$ —	\$ 21,775	\$ —	\$ 290,827
Products	—	207	162	42,214	—	42,583	—	42,583
Services	10,057	14,109	7,760	2,197	—	24,066	—	34,123
Total revenues - unaffiliated customers	279,109	36,091	7,922	44,411	—	88,424	—	367,533
Total revenues - affiliated customers	—	57,696	10,896	71,484	(3,703)	136,373	(136,373)	—
Investment and other income	2,251	1,532	114	192	—	1,838	—	4,089
Total revenues	\$ 281,360	\$ 95,319	\$ 18,932	\$ 116,087	\$ (3,703)	\$ 226,635	\$ (136,373)	\$ 371,622
Total operating costs (a)	\$ 264,945	\$ 88,759	\$ 14,664	\$ 110,972	\$ (3,703)	\$ 210,692	\$ (136,373)	\$ 339,264
Earnings from operations	\$ 16,415	\$ 6,560	\$ 4,268	\$ 5,115	\$ —	\$ 15,943	\$ —	\$ 32,358
Interest expense	—	—	—	—	—	—	(3,246)	(3,246)
Earnings before income taxes	\$ 16,415	\$ 6,560	\$ 4,268	\$ 5,115	\$ —	\$ 15,943	\$ (3,246)	\$ 29,112
Total assets	\$ 110,943	\$ 89,432	\$ 34,173	\$ 51,266	\$ —	\$ 174,871	\$ (12,094)	\$ 273,720
Purchases of property, equipment and capitalized software	866	1,199	974	347	—	2,520	—	3,386
Depreciation and amortization	989	1,058	1,229	696	—	2,983	—	3,972
2022								
Revenues - unaffiliated customers:								
Premiums	\$ 238,783	\$ 18,374	\$ —	\$ —	\$ —	\$ 18,374	\$ —	\$ 257,157
Products	—	72	180	37,172	—	37,424	—	37,424
Services	10,035	10,917	4,996	1,603	—	17,516	—	27,551
Total revenues - unaffiliated customers	248,818	29,363	5,176	38,775	—	73,314	—	322,132
Total revenues - affiliated customers	—	40,883	9,288	60,936	(2,760)	108,347	(108,347)	—
Investment and other income	923	928	117	62	—	1,107	—	2,030
Total revenues	\$ 249,741	\$ 71,174	\$ 14,581	\$ 99,773	\$ (2,760)	\$ 182,768	\$ (108,347)	\$ 324,162
Total operating costs (a)	\$ 235,362	\$ 65,142	\$ 10,993	\$ 95,337	\$ (2,760)	\$ 168,712	\$ (108,347)	\$ 295,727
Earnings from operations	\$ 14,379	\$ 6,032	\$ 3,588	\$ 4,436	\$ —	\$ 14,056	\$ —	\$ 28,435
Interest expense	—	—	—	—	—	—	(2,092)	(2,092)
Earnings before income taxes	\$ 14,379	\$ 6,032	\$ 3,588	\$ 4,436	\$ —	\$ 14,056	\$ (2,092)	\$ 26,343
Total assets	\$ 107,094	\$ 68,950	\$ 31,090	\$ 47,476	\$ —	\$ 147,516	\$ (8,905)	\$ 245,705
Purchases of property, equipment and capitalized software	799	997	698	308	—	2,003	—	2,802
Depreciation and amortization	973	943	841	643	—	2,427	—	3,400

(a) Total operating costs include medical costs, operating costs, cost of products sold and depreciation and amortization, as applicable for each reportable segment.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) designed to provide reasonable assurance the information required to be disclosed by us in reports we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2024. Based upon their evaluation, our Chief Executive Officer and Chief Financial Officer concluded our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2024.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2024 which have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2024

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2024. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control-Integrated Framework (2013). Based on our assessment and the COSO criteria, we believe that, as of December 31, 2024, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2024, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the “Company”) as of December 31, 2024, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2024, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2024, of the Company and our report dated February 27, 2025, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company’s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2024. Our responsibility is to express an opinion on the Company’s internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company’s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company’s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company’s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

February 27, 2025

ITEM 9B. OTHER INFORMATION

Trading Arrangements

During the quarter ended December 31, 2024, none of the Company's directors or officers (as defined in Rule 16a-1(f) under the Exchange Act) adopted or terminated any contract, instruction or written plan for the purchase or sale of Company securities intended to satisfy the affirmative defense conditions of Rule 10b5-1(c) under the Exchange Act or under any non-Rule 10b5-1 trading arrangement.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not Applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The following sets forth certain information regarding our directors as of February 27, 2025, including their name and principal occupation or employment:

Charles Baker

President
National Collegiate Athletic Association

Michele Hooper

Lead Independent Director
UnitedHealth Group
President and Chief Executive Officer
The Directors' Council

Timothy Flynn

Retired Chair
KPMG International

F. William McNabb III

Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Paul Garcia

Retired Chair and Chief Executive Officer
Global Payments Inc.

Valerie Montgomery Rice, M.D.

President and Chief Executive Officer
Morehouse School of Medicine

Kristen Gil

Former Vice President and Business Finance Officer
Alphabet Inc.

John Noseworthy, M.D.

Former Chief Executive Officer and President
Mayo Clinic

Stephen Hemsley

Chair
UnitedHealth Group

Andrew Witty

Chief Executive Officer
UnitedHealth Group

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Part I, Item 1 under the caption "Information About our Executive Officers."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at www.unitedhealthgroup.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance" and "Proposal 1-Election of Directors" in our definitive proxy statement for our 2025 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

The information required by Item 408(b) of Regulation S-K will be included under the heading "Insider Trading Policy" in our definitive proxy statement for our 2025 Annual Meeting of Shareholders, and such required information is incorporated herein by reference. A copy of our insider trading policy is filed as Exhibit 19.1 to this Form 10-K.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402 and 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings “Executive Compensation,” “Director Compensation,” “Corporate Governance - Risk Oversight” and “Compensation Committee Interlocks and Insider Participation” in our definitive proxy statement for our 2025 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information as of December 31, 2024, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders ⁽¹⁾	17	\$ 370	64 ⁽³⁾
Equity compensation plans not approved by shareholders ⁽²⁾	—		—
Total ⁽²⁾	17	\$ 370	64

(1) Consists of the UnitedHealth Group Incorporated 2020 Stock Incentive Plan (the “2020 Stock Incentive Plan”), as amended, and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended (the “ESPP”).

(2) Excludes 60,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of \$373 and an average remaining term of approximately 2.4 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 16 million shares of common stock available for future issuance under the ESPP as of December 31, 2024, and 48 million shares available under the 2020 Stock Incentive Plan as of December 31, 2024. Shares available under the 2020 Stock Incentive Plan may become the subject of future awards in the form of stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading “Security Ownership of Certain Beneficial Owners and Management” in our definitive proxy statement for our 2025 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings “Certain Relationships and Transactions” and “Corporate Governance” in our definitive proxy statement for our 2025 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading “Disclosure of Fees Paid to Independent Registered Public Accounting Firm” in our definitive proxy statement for our 2025 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2024 and 2023.
- Consolidated Statements of Operations for the years ended December 31, 2024, 2023, and 2022.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2024, 2023, and 2022.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2024, 2023, and 2022.
- Consolidated Statements of Cash Flows for the years ended December 31, 2024, 2023, and 2022.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I - Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

- (b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

- 3.1 Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
- 3.2 Amended and Restated Bylaws of UnitedHealth Group Incorporated, effective February 23, 2021 (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 26, 2021)
- 4.1 Amended and Restated Indenture, dated as of April 27, 2023, between UnitedHealth Group Incorporated and Wilmington Trust Company, as successor trustee (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on April 28, 2023)
- 4.2 Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
- 4.3 Supplemental Indenture, dated as of April 18, 2023, between UnitedHealth Group Incorporated and U.S. Bank Trust Company, National Association, as trustee, relating to the 6.875% Senior Notes due 2038 (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on April 24, 2023)
- 4.4 Description of Common Stock (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
- *10.1 UnitedHealth Group 2020 Stock Incentive Plan (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8, SEC File Number 333-238854, filed on June 1, 2020)
- *10.2 Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (2024 Version) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2023)
- *10.3 Form of Agreement for Nonqualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (2024 Version) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2023)
- *10.4 Form of Agreement for Performance-Based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (2024 Version) (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2023)

- *10.24 Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
- *10.25 Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
- *10.26 Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
- *10.27 Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2023 (incorporated by reference to exhibit 10.30 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2023)
- *10.28 UnitedHealth Group Executive Savings Plan (2024 Statement) (incorporated by reference to Exhibit 10.31 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2023)
- *10.29 Executive Long-Term Disability Program, dated as of January 1, 2021 (incorporated by reference to Exhibit 10.28 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2022)
- *10.30 Summary of Non-Management Director Compensation, effective as of October 1, 2022 (incorporated by reference to Exhibit 10.29 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2022)
- *10.31 UnitedHealth Group Directors' Compensation Deferral Plan (2023 Statement) (incorporated by reference to Exhibit 10.30 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2022)
- *10.32 Avery Parent Holdings, Inc. 2020 Stock Option and Grant Plan (incorporated by reference to Exhibit 10.31 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2022)
- *10.33 Change Healthcare Inc. 2019 Omnibus Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-267716, filed on October 3, 2022)
- *10.34 Amended and Restated HCIT Holdings, Inc. 2009 Equity Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-267716, filed on October 3, 2022)
- *10.35 Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
- *10.36 Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.37 Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.38 Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.39 Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
- *10.40 The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
- *10.41 The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
- *10.42 Amended and Restated Employment Agreement, effective as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
- *10.43 Amended and Restated Employment Agreement, dated February 3, 2021, between the Company and Andrew P Witty (incorporated by reference to Exhibit 5.02 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 8, 2021)
- *10.44 Amended and Restated Employment Agreement, effective as of February 12, 2018, between United HealthCare Services, Inc. and Brian R. Thompson (incorporated by reference to Exhibit 10.38 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
- *10.45 Amended and Restated Employment Agreement, effective as of April 1, 2024, between United HealthCare Services, Inc. and Heather Cianfrocco

- *10.46 Employment Agreement, effective as of January 9, 2017, between United HealthCare Services, Inc. and Erin McSweeney
- *10.47 Amendment to Employment Agreement, effective as of March 1, 2021, between United HealthCare Services, Inc. and Erin McSweeney
- *10.48 Amended and Restated Employment Agreement, effective as of June 4, 2024, between United HealthCare Services, Inc. and Christopher Zaetta
- 19.1 Insider Trading Policy
- 21.1 Subsidiaries of UnitedHealth Group Incorporated
- 23.1 Consent of Independent Registered Public Accounting Firm
- 24.1 Power of Attorney
- 31.1 Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
- 32.1 Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
- 97.1 UnitedHealth Group Dodd-Frank Clawback Policy, effective December 1, 2023 (incorporated by reference to Exhibit 97.1 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2023)
- 101.INS XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
- 101.SCH Inline XBRL Taxonomy Extension Schema Document.
- 101.CAL Inline XBRL Taxonomy Extension Calculation Linkbase Document.
- 101.DEF Inline XBRL Taxonomy Extension Definition Linkbase Document.
- 101.LAB Inline XBRL Taxonomy Extension Label Linkbase Document.
- 101.PRE Inline XBRL Taxonomy Extension Presentation Linkbase Document.
- 104 Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

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- * Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.
 - ** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I - Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the “Company”) as of December 31, 2024 and 2023, and for each of the three years in the period ended December 31, 2024, and the Company’s internal control over financial reporting as of December 31, 2024, and have issued our reports thereon dated February 27, 2025; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company’s management. Our responsibility is to express an opinion on the Company’s financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

February 27, 2025

Schedule I

**Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets**

(in millions, except per share data)	December 31, 2024	December 31, 2023
Assets		
Current assets:		
Cash and cash equivalents	\$ 234	\$ 776
Other current assets	411	570
Total current assets	645	1,346
Equity in net assets of subsidiaries	179,209	153,692
Long-term notes receivable from subsidiaries	6,062	5,693
Other assets	920	831
Total assets	\$ 186,836	\$ 161,562
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	\$ 1,501	\$ 1,116
Short-term notes payable to subsidiaries	2,016	9,887
Short-term borrowings and current maturities of long-term debt	4,348	4,086
Total current liabilities	7,865	15,089
Long-term debt, less current maturities	71,831	57,387
Long-term notes payable to subsidiaries	14,405	—
Other liabilities	77	330
Total liabilities	94,178	72,806
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, \$0.001 par value -10 shares authorized; no shares issued or outstanding	—	—
Common stock, \$0.01 par value - 3,000 shares authorized; 915 and 924 issued and outstanding	9	9
Retained earnings	96,036	95,774
Accumulated other comprehensive loss	(3,387)	(7,027)
Total UnitedHealth Group shareholders' equity	92,658	88,756
Total liabilities and shareholders' equity	\$ 186,836	\$ 161,562

See Notes to the Condensed Financial Statements of Registrant

Schedule I

**Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income**

(in millions)	For the Years Ended December 31,		
	2024	2023	2022
Revenues:			
Investment and other income	\$ 368	\$ 312	\$ 255
Total revenues	368	312	255
Operating costs:			
Operating costs	108	35	121
Interest expense	4,544	3,469	2,110
Total operating costs	4,652	3,504	2,231
Loss before income taxes	(4,284)	(3,192)	(1,976)
Benefit for income taxes	1,032	654	429
Loss of parent company	(3,252)	(2,538)	(1,547)
Equity in undistributed income of subsidiaries	17,657	24,919	21,667
Net earnings	14,405	22,381	20,120
Other comprehensive income (loss)	3,640	1,366	(3,009)
Comprehensive income	<u>\$ 18,045</u>	<u>\$ 23,747</u>	<u>\$ 17,111</u>

See Notes to the Condensed Financial Statements of Registrant

Schedule I

**Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows**

(in millions)	For the Years Ended December 31,		
	2024	2023	2022
Operating activities			
Cash flows from operating activities	\$ 4,852	\$ 17,443	\$ 14,754
Investing activities			
Issuances of notes to subsidiaries	(349)	(41)	(567)
Repayments of notes to subsidiaries	225	817	281
Cash paid for acquisitions and other transactions	(13,750)	(8,144)	(20,728)
Return of capital to parent company	21	639	1,424
Capital contributions to subsidiaries	—	(2,472)	(570)
Cash received from dispositions, net	2,444	624	2,787
Other, net	30	286	—
Cash flows used for investing activities	(11,379)	(8,291)	(17,373)
Financing activities			
Common stock repurchases	(9,000)	(8,000)	(7,000)
Proceeds from common stock issuances	1,846	1,353	1,253
Cash dividends paid	(7,533)	(6,761)	(5,991)
(Repayments of) proceeds from short-term borrowings, net	(151)	11	732
Proceeds from issuance of long-term debt	17,811	6,394	14,819
Repayments of long-term debt	(3,000)	(2,125)	(3,015)
(Repayments of) proceeds from short-term notes from subsidiaries, net	(7,966)	1,188	594
Proceeds from long-term notes from subsidiaries	14,396	—	—
Repayments of long-term notes from subsidiaries	(28)	—	—
Other, net	(390)	(702)	(674)
Cash flows from (used for) financing activities	5,985	(8,642)	718
(Decrease) increase in cash and cash equivalents	(542)	510	(1,901)
Cash and cash equivalents, beginning of period	776	266	2,167
Cash and cash equivalents, end of period	\$ 234	\$ 776	\$ 266
Supplemental cash flow disclosures			
Cash paid for interest	\$ 4,241	\$ 3,257	\$ 1,969
Cash paid for income taxes	2,450	4,426	4,298

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant (Parent Company Only) UnitedHealth Group Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were \$19.3 billion, \$18.5 billion and \$15.6 billion in 2024, 2023 and 2022, respectively. Additionally, \$21 million, \$639 million and \$1.4 billion in cash were received as a return of capital to the parent company during 2024, 2023 and 2022, respectively.

3. Short-Term Borrowings and Long-Term Debt

Discussion of short-term borrowings and long-term debt can be found in Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries which totaled \$0.7 billion and \$1.1 billion at December 31, 2024 and 2023.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2025	\$ 4,350
2026	3,650
2027	3,425
2028	3,000
2029	3,550
Thereafter	59,802

UnitedHealth Group's parent company had short-term notes payable to subsidiaries of \$2.0 billion and \$9.9 billion as of December 31, 2024 and 2023, respectively, which included on-demand features. UnitedHealth Group's parent company had long-term notes payable to subsidiaries of \$14.4 billion as of December 31, 2024.

4. Commitments and Contingencies

Certain subsidiaries are guaranteed by UnitedHealth Group's parent company in the event of insolvency. UnitedHealth Group's parent company also provides guarantees related to its service level under certain contracts. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2024, 2023 or 2022.

For a summary of commitments and contingencies, see Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 27, 2025

UNITEDHEALTH GROUP INCORPORATED

By /s/ ANDREW WITTY

Andrew Witty
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
<u> /s/ ANDREW WITTY </u> Andrew Witty	Director and Chief Executive Officer (principal executive officer)	February 27, 2025
<u> /s/ JOHN REX </u> John Rex	President and Chief Financial Officer (principal financial officer)	February 27, 2025
<u> /s/ THOMAS ROOS </u> Thomas Roos	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 27, 2025
<u> * </u> Charles Baker	Director	February 27, 2025
<u> * </u> Timothy Flynn	Director	February 27, 2025
<u> * </u> Paul Garcia	Director	February 27, 2025
<u> * </u> Kristen Gil	Director	February 27, 2025
<u> * </u> Stephen Hemsley	Director	February 27, 2025
<u> * </u> Michele Hooper	Director	February 27, 2025
<u> * </u> F. William McNabb III	Director	February 27, 2025
<u> * </u> Valerie Montgomery Rice, M.D.	Director	February 27, 2025
<u> * </u> John Noseworthy, M.D.		

*By /s/ CHRISTOPHER ZAETTA

Christopher Zaetta
As Attorney-in-Fact

STATE OF NEBRASKA

United States of America, }
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, Robert B. Evnen, Secretary of State of the
State of Nebraska, do hereby certify that

UNITED HEALTHCARE SERVICES, INC.

a Minnesota corporation is authorized to transact business in Nebraska;

**that no occupation taxes due from and assessable against the Corporation are
unpaid and have become delinquent;**

**that no annual or biennial report required to be forwarded by the
Corporation to the Secretary of State has become delinquent;**

that a Certificate of Withdrawal has not been filed.

*This certificate is not to be construed as an endorsement,
recommendation, or notice of approval of the entity's financial
condition or business activities and practices.*

In Testimony Whereof,

I have hereunto set my hand and
affixed the Great Seal of the
State of Nebraska on this date of

July 8, 2025



A handwritten signature in black ink, reading "Robert B. Evnen".

Secretary of State

ATTACHMENT C1- CONFIRMATIONS - QUESTIONNAIRE

SOLICITATION NUMBER - 122436 O5

CONFIRMATIONS TAB

SECTION C. FINANCIAL GENERAL

C. 6. PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and logic associated with traditional claims.

Not confirmed. The dispensing fee for compounded medications is currently \$7.50.

QUESTIONNAIRE TAB

SECTION G. MAIL ORDER

G. 14. What is your standard floor limit for accepting prescription orders from members without the correct payment?

We encourage members experiencing difficulty in paying for prescription orders to take advantage of our Easy Payment Plan, which allows the member to pay for 90-day supplies of maintenance medication over three installments. To further support therapy adherence for those in need of further assistance we extend a \$250 ship-and-bill or floor limit to members. In the case of nonpayment, a prescription may be shipped by request to the member if the total of the order and the outstanding balance does not exceed the standard ship-and-bill limit of \$250. The member receives a bill for the copayment amount due.

SECTION H. SPECIALTY PHARMACY

H. 14. Provide a brief recommendation of how you would propose to collaborate with the State's medical carriers to optimize patient care and utilization of specialty drugs.

UnitedHealthcare has rigorous, independent clinical management processes. Our utilization management criteria are grounded in a robust, comprehensive library of clinical criteria that are reviewed multiple times each year by the Pharmacy and Therapeutics committee. We proactively manage the pipeline of pharmacy and medical benefit medications, analyzing medications 12 to 36 months prior to approval, to develop strategies that manage care and cost.

This process addresses clinical appropriateness, medical necessity and employee/provider experiences, to boost efficiency without compromising clinical rigor. Our utilization management offerings also help control costs and manage employee disruption.

UnitedHealthcare also offers multiple strategies to make sure employees get the medications they need and adhere to therapy, while reducing waste. Our Specialty Medical Guidance program uses a single platform to analyze pathway regimens and review prior authorizations. It also gives providers patient-specific guidance based on clinical evidence. The approval process takes only five minutes (or less) with selection of recommended therapies, and 99 percent of employees with cancer start on the right evidence-based, cost-effective therapy. In addition, our strategies balance maintaining adherence with limiting oversupply by avoiding auto-refill programs. For oncology, we offer a Split Fill program that avoids costs associated with waste when patients discontinue therapy early. Program savings average \$6,410 per patient per year.

Integrated medical, pharmacy and specialty care put the employee first. Systematic end-to-end specialty medication management uses medical and pharmacy data to ensure the right specialty medication strategy at every step by providing the right medication, for the right cost, in the right setting, with the right support. At no point is the employee left alone with nowhere to turn. Nor do caregivers lack a complete picture of the employee. Our integrated approach offers not only better cost; it's better whole-person care.

Our clinical management programs are a core value. We offer employees a personalized approach to drug utilization reviews and safety checks, helping to prevent adverse drug-drug interactions.

Our analysis has shown that integrating prior authorizations with the employee's full treatment history, including medical and pharmacy interactions, means employees start therapy faster and on the right medication. In partnership with Optum, UnitedHealthcare has an extensive national footprint to provide clinical support. The pharmacy holds accreditations from nationally recognized bodies, demonstrating our commitment to exceed specialty pharmacy requirements. Currently, we hold accreditations from the Accreditation Commission for Health Care (ACHC), the National Association of Boards of Pharmacy (NABP) and URAC®

An integrated approach also simplifies treatment selection. Providers who use our prior authorization portal and pathways receive approval more than 98 percent of the time, ensuring the right treatment can start without delay.

UnitedHealthcare gives employers the insights, guidance and flexible offerings that meet their needs. Our integrated approach includes a strong clinical foundation and strategies to drive therapies to their lowest net cost. It also eliminates waste and neutralizes abusive pricing tactics by pharmaceutical manufacturers. Wide-ranging solutions and a holistic approach help address the major cost drivers of both specialty medications and complex conditions.



November 12, 2024

Optum
11000 Cir
Eden Prairie, Minnesota 55344-2503

Based upon the procedures performed by an Authorized External Assessor which indicated that there were no material changes to the control environment that would result in Optum ("the Organization") no longer meeting certification criteria of the HITRUST Risk-based, 2-year (r2) certification, the following platforms, facility, and supporting infrastructure of the Organization ("Scope") continue to meet the HITRUST CSF® v11.1.0 Risk-based, 2-year (r2) certification criteria:

Platforms:

- HospiDirect residing at Optum Data Center
- HospiTrac residing at Optum Data Center
- HospiTrac iRX residing at Optum Data Center
- IRIS - Integrated Rx Information System residing at Optum Data Center
- ORx Customer Communication Management residing at Optum Data Center
- ORx Distributed Order Management System residing at Optum Data Center
- ORx Transportation Management System residing at Optum Data Center
- ORx Warehouse Management System residing at Optum Data Center
- PreCheck MyScript residing at Optum Data Center
- RXBUILDER residing at Optum Data Center
- RXCLAIM Benefit and Eligibility Operations residing at Optum Data Center
- RxClaim modern residing at Optum Data Center
- RXCLAIM RXBK1 Pharmacy Benefits Management System(formerly RXCLAIM PHARMACY CLAIMS ADJUDICATION (UHCMR UHCCS and DIRECT) residing at Optum Data Center
- RXCLAIM RXBK2 Pharmacy Benefits Management System(Formerly RxClaim Pharmacy Claims Adjudication (E and I)) residing at Optum Data Center
- RXCLAIM RXCL1 Pharmacy Benefits Management System residing at Optum Data Center
- RXCLAIM RXCL2 Pharmacy Benefits Management System residing at Optum Data Center
- RXCLAIM RXCL3 Pharmacy Benefits Management System residing at Optum Data Center
- RXCLAIM RXCL4 Pharmacy Benefits Management System residing at Optum Data Center
- RXCLAIM RXCL5 Pharmacy Benefits Management System residing at Optum Data Center
- RxCLAIM Web Interface residing at Optum Data Center

- RXMAX (OptumRx - Direct and Health plans) residing at Optum Data Center
- RxMAX-O residing at Optum Data Center
- RxTrack IDW - Integrated Data Warehouse residing at Optum Data Center
- STERLING INTEGRATOR residing at Optum Data Center

Facility:

- Optum Data Center (Data Center) located in Elk River Chaska, Plymouth, Minnesota, United States of America

The initial certification was awarded to the Organization on 11/9/2023 and is valid for a period of two years assuming the following occurs:

- Annual progress is being made on areas identified in the Corrective Action Plan(s) (CAPs).
- No data security breach reportable to a federal or state agency by law or regulation has occurred within or affecting the assessed environment.
- Either no significant changes in the business or security policies, practices, controls and processes have occurred that might impact its ability to continue to meet the respective HITRUST Assurance Program criteria, or—where there were changes—procedures performed by the external assessor indicate the Organization's control environment continues to meet the criteria against which the Organization was initially assessed.

Based upon the work performed by the Organization's external assessor, HITRUST is of the opinion that the requirements of the HITRUST v11.1.0 Risk-based, 2-year (r2) certification continue to be met.

Additional information on the HITRUST Assurance Program can be found at the HITRUST website at <https://hitrustalliance.net>.

A stylized, handwritten signature of the word 'HITRUST' in dark ink.

HITRUST

State of Nebraska Department of Administrative Services
REQUEST FOR PROPOSAL FOR SERVICES CONTRACT

SOLICITATION NUMBER	RELEASE DATE
122436 O5	June 9, 2025
OPENING DATE AND TIME	PROCUREMENT CONTACT
July 18, 2025 2:00 p.m. Central Time	Brook Taylor

PLEASE READ CAREFULLY!
SCOPE OF SERVICE

The State of Nebraska (State), Department of Administrative Services (DAS), Materiel Division, State Purchasing Bureau (SPB), is issuing this solicitation for a service contract for the purpose of selecting a qualified bidder to provide Administrative Support Services for the State of Nebraska Employee Health Care Prescription Drug Benefit Plans. A more detailed description can be found in Section V. The resulting contract may not be an exclusive contract as the State reserves the right to contract for the same or similar services from other sources now or in the future.

The term of the contract will commence upon execution of the contract by the State and the Vendor through June 30, 2029.. The Contract includes the option to renew for two (2) additional one (1) year renewal periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Parties.

In the event that a contract with the awarded bidder(s) is cancelled or in the event that the State needs additional Vendors to supply the solicited services, this solicitation may be used to technical procure the solicited services for up to eighteen (18) months from the date the Intent to Award is posted, provided that 1) the solicited goods or services will be provided by a bidder (or a successive owner) who submitted a response pursuant to this solicitation, 2) the bidder's solicitation response was evaluated, and 3) the bidder will honor the bidder's original solicitation response, including the proposed cost, allowing for any price increases that would have otherwise been allowed if the bidder would have received the initial award.

ALL INFORMATION PERTINENT TO THIS SOLICITATION CAN BE FOUND ON THE INTERNET AT:
<https://das.nebraska.gov/materiel/bidopps.html>.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the Solicitation, and the awarded solicitation response will be posted to a public website managed by DAS, which can be found at <http://statecontracts.nebraska.gov> and https://www.nebraska.gov/das/materiel/purchasing/contract_search/index.php.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all responses received regarding this Solicitation will be posted to the State Purchasing Bureau public website.

These postings will include the entire solicitation response. Bidder must request that proprietary information be excluded from the posting. The bidder must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate file named conspicuously as "PROPRIETARY INFORMATION". The bidder should submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992). **THE BIDDER MAY NOT ASSERT THAT THE ENTIRE SOLICITATION IS PROPRIETARY. COST SHEETS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA.** The State will determine, in its sole discretion, if the disclosure of the information designated by the Bidder as proprietary would 1) give advantage to business competitors and 2) serve no public purpose. The Bidder will be notified of the State's decision. Absent a determination by the State that the information may be withheld pursuant to Neb. Rev. Stat. § 84-712.05, the State will consider all information a public record subject to disclosure.

If the State determines it is required to release withheld proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

Confirmed. Please refer to "122436 O5 UnitedHealthcare Pharmacy - Proprietary Information" provided with our proposal response.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty -free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, or solicitation response for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a solicitation response, specifically waives any copyright or other protection the contract, or solicitation response may have; and acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver are a prerequisite for submitting a solicitation response, and award of a contract. Failure to agree to the reservation and waiver will result in the solicitation response being found non-responsive and rejected.

This proposal is provided in response to a request to bid; information included in the proposal is to be used only in that context.

Any entity awarded a contract or submitting a solicitation response agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against

any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or solicitation response, awards, and other documents.

This RFP and Bidder response to all attachments associated with this RFP, including all subsequent documents provided during this RFP process, will become part of the contract terms and policy between the parties.

United agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of United, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent United's liability is attenuated by any action of the State which directly and proximately contributed to the claims.

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State or other sources of testing standards, for measuring the effectiveness of products or goods and the means used for testing such performance

Addendum: A written correction or alteration to a document during the solicitation process (e.g., Questions and Answers, Revised Schedule of Events, Addendum to Contract Award)

Agency: All officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations

Agent/Representative: A person authorized to act on behalf of another

Amend: To alter or change by adding, subtracting, or substituting

Amendment: A written correction or alteration to a document

Appropriation: Legislative authorization to expend public funds for a specific purpose; money set apart for a specific use

Automated Clearing House (ACH): Electronic network for financial transactions in the United States

Award: All purchases, leases, or contracts which are based on competitive solicitations will be awarded according to the provisions in the solicitation

Best and Final Offer (BAFO): In a competitive solicitation, the final offer submitted which contains Vendor's most favorable terms for price

Bid: See Solicitation Response

Bid Opening: The process of opening correctly submitted solicitation responses at the time and place specified in the written solicitation and in the presence of any bidder who wishes to attend

Bidder: A Vendor who submits a Solicitation Response

Breach: Violation of a contractual obligation by failing to perform or repudiation of one's own promise

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity

Business Day: Any weekday, except State-recognized holidays

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays

Cancellation: To call off or revoke a solicitation, purchase order, or contract without expectation of conducting or performing at a later time

Catalog/Non-Core: A printed or electronic list of products a Vendor may provide at a discounted rate or discount off list price to the State. Initial contract award(s) is not based on Catalog/Non-Core items

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software

Change Order: Document that provides amendments to an executed purchase order or contract

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose

Commodities: Any equipment, material, supply, or goods; anything movable or tangible that is provided or sold

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties

Confidential Information: See Proprietary Information

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement

Contract Administration: The management of the contract which includes and is not limited to contract signing, contract amendments and any necessary legal actions

Contract Award: Document that officially awards a contract to a bidder(s) as the result of a competitive solicitation or a vendor(s) in a contract that qualifies for an exception or exemption from the competitive bidding requirements of the State Procurement Act

Contract Management: The management of day-to-day activities at the agency which includes but is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Vendor

Contract Period: The duration of the contract

Contractor: See Vendor

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work

Cost Sheet: A required document that is completed by the vendor in the prescribed format to show the vendor's pricing to provide the commodities or perform the services requested.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those commodities or services provided by a Vendor

Default: The omission or failure to perform a contractual duty

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract

Evaluation: The process of examining a solicitation response after opening to determine the bidder's responsibility, responsiveness to requirements, and to ascertain other characteristics of the solicitation response that relate to determination of the successful award

Evaluation Committee: Individual(s) identified by the agency that leads the solicitation to evaluate solicitation responses

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period; not to be confused with "Renewal Period"

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the Vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country

Goods: See Commodities

Installation Date: The date when the procedures described in "Installation by Vendor" and "Installation by State" as found in the solicitation or contract are completed

Interested Party: A person acting in their personal capacity or an entity entering into a contract or other agreement creating a legal interest therein

Late Solicitation Response: A solicitation response received after the Opening Date and Time

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Vendor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently

Mandatory: Required, compulsory, or obligatory

May: Discretionary, permitted; used to express possibility

Module (see System): A collection of routines and data structures that perform a specific function of software

Must: See Shall

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services

Non-core: See Catalog

Non-Responsive Solicitation Response: Any solicitation response that does not comply with the requirements of the solicitation or cannot be evaluated against the other solicitation responses

Nonnegotiable: These clauses are controlled by state law and are not subject to negotiation

Opening Date and Time: Specified date and time for the opening of received, labeled, and sealed formal solicitation responses

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources

Outsourcing: The contracting out of a business process that an organization may have previously performed internally or for which an organization has a new need to an independent organization from which the process is purchased back

Payroll & Financial Center (PFC): Electronic procurement system of record

Performance Bond: An insurance agreement accompanied by a monetary commitment by which a third party (the surety) accepts liability and guarantees that the Vendor fulfills any and all obligations under the contract

Personal Property: See Commodities

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination

Point of Contact (POC): The person designated to receive communications and to communicate

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption

Program Error: Code in Licensed Software that produces unintended results or actions or that produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the solicitation, plus any additional programs and products licensed by the State under the contract for use by the State

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract

Proposal: See Solicitation Response

Proprietary Information: Trade secrets, academic and scientific research work that is in progress and unpublished or other information that if released would give advantage to business competitors and service no public purpose. See Neb. Rev. Stat.

§ 84-712.05(3). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance:

A complaint about a governmental action or decision related to the solicitation or resultant contract under SPB's Protest Policy.

Quote: See Solicitation Response

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent used by the State as recommended by the Vendor

Release Date: The date of public release of the solicitation

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions; not to be confused with "Extension"

Request for Proposal (RFP): See Solicitation

Responsible Bidder: A Vendor who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance

Responsive Bidder: A Vendor who has submitted a solicitation response which conforms to all requirements of the solicitation

Shall: An order/command; mandatory

Should: Expected; suggested, but not necessarily mandatory

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software

Solicitation: A formal invitation to receive quotes in the form of a Request for Proposal or Invitation to Bid

Solicitation Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Vendor will not withdraw the solicitation response

Solicitation Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations

Solicitation Response: An offer, quote, bid, or proposal submitted by a Vendor in response to a Solicitation

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract

Subcontractor: Individual or entity with whom the Vendor enters a contract to perform a portion of the work awarded to the Vendor

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Vendor as functioning or being capable of functioning, as an entity

Termination:

Occurs when either Party, under a power created by agreement or law, puts an end to the contract prior to the stated expiration date; all obligations that are still executory on both sides are discharged but any right based on prior breach or performance survives

Third-Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and subcontractors or agents, and their employees. It shall not include any entity or person who is an interested party to the contract or agreement

Trade Secret: Information, including but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. § 87-502(4))

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or Vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office

Upgrade: Any change that improves or alters the basic function of a product of service

Vendor: An individual or entity lawfully conducting business with the State, or licensed to do so, who seeks to provide and contract for goods or services under the terms of a Solicitation and/or Contract

Vendor Performance Report: A report completed by the using agency and submitted to State Purchasing Bureau documenting products or services delivered or performed which exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications

Will: See Shall

Work Day: See Business Day

ACRONYM LIST

ACH – Automated Clearing House

ARO – After Receipt of Order

BAFO – Best and Final Offer

COI – Certificate of Insurance

CPU – Central Processing Unit

DAS – Department of Administrative Services

F.O.B. – Free on Board

ICT – Information and Communication Technology

ITB – Invitation to Bid

NIGP – National Institute for Governmental Purchasing

PA – Participating Addendum

RFP – Request for Proposal

SPB – State Purchasing Bureau

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

This solicitation is designed to solicit responses from qualified bidders who will be responsible for providing Administrative Support Services for the State of Nebraska Employee Health Care Prescription Drug Benefit Plans at a competitive and reasonable cost.

Solicitation responses shall conform to all instructions, conditions, and requirements included in the solicitation. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this solicitation, and respond to each requirement in the format prescribed. Solicitation responses may be found non-responsive if they do not conform to the solicitation.

Noted.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this solicitation reside with the State Purchasing Bureau. The point of contact (POC) for the procurement is as follows:

RFP Number: 122436 O5
Name: Brook Taylor, Procurement Contract Officer
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: 402-471-6500
E-Mail: as.materielpurchasing@nebraska.gov

From the date the solicitation is issued until the Intent to Award is issued, communication from the bidder is limited to the POC listed above. After the Intent to Award is issued, the bidder may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this solicitation. The POC will issue any answers, clarifications, or amendments regarding this solicitation in writing. Only the SPB or awarding agency can award a contract. Bidders shall not have any communication with or attempt to communicate or influence any evaluator involved in this solicitation.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;
2. Contact required by the schedule of events or an event scheduled later by the POC; and
3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a bidder's solicitation response, withdraw an Intent to Award, or terminate a contract if the State determines it to be in the best interest of the State

Noted.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

NOTE: All ShareFile links in the Schedule of Events below, are unique links for each schedule step. Please click the correct link for the upload step you are requesting.

Schedule of Events		
ACTIVITY		DATE/TIME
1.	Release solicitation	June 9, 2025
2.	Last day to submit "Attachment A - Intent to Propose Form" See Section I.H. for submission instructions.	June 18, 2025
3.	Last day to submit written questions – Round 1 ShareFile link for uploading questions: https://nebraska.sharefile.com/r-rc57d4dcb9ffd4c33b80443517e6a3287	June 22, 2025
4.	State responds to Round 1 of written questions through solicitation "Addendum" to be posted to the Internet at: http://das.nebraska.gov/materiel/bidopps.html	June 26, 2025
5.	Last day to submit written questions – Round 2 ShareFile link for uploading questions: https://nebraska.sharefile.com/r-r9db21bad1e7347349072c5a14110b83e	July 6, 2025
6.	State responds to Round 2 of written questions through solicitation "Addendum" to be posted to the Internet at: http://das.nebraska.gov/materiel/bidopps.html	July 9, 2026
7.	Electronic Solicitation Opening – Online Via Webex IT IS THE BIDDER'S RESPONSIBILITY TO UPLOAD ELECTRONIC FILES BY OPENING DATE AND TIME. EXCEPTIONS WILL NOT BE MADE FOR TECHNOLOGY ISSUES. ShareFile Electronic Solicitation Submission Link: https://nebraska.sharefile.com/r-rff7db5fffc8c4fe59d2e4601cfc003db Join Webex Meeting https://sonvideo.webex.com/sonvideo/j.php?MTID=mf31ddcae5249bd04e07bddd8328f4576 Webinar number: 2497 360 3976 Webinar password: 2XAdm5dXE8N (29236539 when dialing from a phone or video system) Agenda: 122436 O5 Electronic Solicitation Opening Join by video system Dial 24973603976@sonvideo.webex.com You can also dial 173.243.2.68 and enter your webinar number. Join by phone +1-408-418-9388 United States Toll Access code: 2497 360 3976 Global call-in numbers	July 18, 2025 2:00 PM Central Time
8.	Review for conformance to solicitation requirements	July 18 - 24, 2025
9.	Evaluation period	July 24, 2025 - TBD
10.	"Vendor Demonstrations" (if required)	TBD
11.	Post "Notification of Intent to Award" to Internet at: https://das.nebraska.gov/materiel/bidopps.html	October 10, 2025
12.	Contract finalization period	October 10, 2025 - TBD
13.	Contract award	TBD
14.	Benefit plan year begins	July 1, 2026

Noted.

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any solicitation provision must be submitted in writing to State Purchasing Bureau and clearly marked "Solicitation Number 122436 O5; Administrative Support Services for the State of Nebraska Employee Health Care Prescription Drug Benefit Plans Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should submit questions for any items upon which assumptions may be made when preparing a response to the solicitation. Any solicitation response containing assumptions may be deemed non-responsive and may be rejected by the State. Solicitation responses will be evaluated without consideration of any known or unknown assumptions of a bidder. The contract will not incorporate any known or unknown assumptions of a bidder.

Questions should be uploaded using the ShareFile link provided in the solicitation Schedule of Events, Section I.C. It is recommended that bidders submit questions using the following format:

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at <https://das.nebraska.gov/materiel/bidopps.html> per the Schedule of Events.

Noted.

E. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Nonnegotiable)

All bidders must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The bidder who is the recipient of an Intent to Award may be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at:

<https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf> This should be accomplished prior to execution of the contract.

Confirmed. Please refer to "122436 O5 UnitedHealthcare Pharmacy - Certificate of Good Standing - NE - UHS (2025-07-08)" provided with our proposal response.

F. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject solicitation responses, withdraw an intent to award or award, or terminate a contract if an ethical violation has been committed, which includes, but is not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;

Noted.

2. Utilizing the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;

Noted.

3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:

Agreed.

4. Submitting a solicitation response on behalf of another Party or entity; and

Noted.

5. Colluding with any person or entity to influence the bidding process, submit sham solicitation responses, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the solicitation response, or

prejudice the State.

Noted.

The bidder shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Noted. Please note that we are unable to agree to include these provisions in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been had we performed those services without the use of a subcontractor.

Bidder shall have an affirmative duty to report any violations of this clause by the bidder throughout the bidding process and throughout the term of this contract for the awarded bidder and their subcontractors.

Noted.

G. DEVIATIONS FROM THE SOLICITATION

The requirements contained in the solicitation (Sections II through VI) become a part of the terms and conditions of the contract resulting from this solicitation. Any deviations from the solicitation in Sections II through VI must be clearly defined by the bidder in its solicitation response and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the solicitation, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this solicitation, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this solicitation. The State discourages deviations and reserves the right to reject proposed deviations.

Noted.

H. SECURE DATA

If Bidder intends to submit a proposal for this procurement, and wishes to access the secure data (e.g., claims, census, etc.) in connection with this procurement, please complete the Intent to Propose Form attached to this RFP. The Intent to Propose Form is to be emailed to mcasarez@segalco.com. Upon receipt of the Intent to Propose Form,

Segal, the State's Health and Actuarial Consultant, will review its files for a current Global or Bid-Related NDA/Confidentiality Agreement. If there is a NDA/Confidentiality Agreement on file with Segal, Segal will send an email to the Bidder, with the existing, fully executed agreement on file to confirm it may be used in connection with this RFP. Once confirmed, Segal will send the data securely to the interested Bidder, using the designated data contact information in the Intent to Propose Form, as appropriate. If there is no NDA/Confidentiality Agreement on file with Segal, an NDA document will be issued to the interested Bidder for signature. **Verbiage is non-negotiable.** Upon receipt of the newly signed NDA, or confirmation of an existing NDA on file, the data will be securely released to the Offeror via Segal's Secure File Transfer (SFT) system. Bidders must register to use the SFT site in order to obtain the data.

Secure data will not be released until Bidder's Intent to Propose form is submitted and a signed NDA between the Vendor and Segal is in place.

Noted.

I. SUBMISSION OF SOLICITATION RESPONSES

The State is only accepting electronic responses submitted in accordance with this solicitation. The State will not accept solicitation responses by mail, email, voice, or telephone, unless otherwise explicitly stated in writing by the State.

Pages may be consecutively numbered for the entire solicitation response or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text.

The Technical Responses should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Response so that the bidder's understanding of the scope of work may be evaluated. The Technical Response shall disclose the bidder's technical requirements in as much detail as possible, including, but not limited to, the information required by the Technical Response instructions.

It is the bidder's responsibility to ensure the solicitation response is received electronically by the date and time indicated in the Schedule of Events. Solicitation Responses must be submitted via ShareFile by the date and time of the opening per the Schedule of Events. No late solicitation responses will be accepted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. The website can be found here: <https://das.nebraska.gov/materiel/bidopps.html>.

Emphasis should be concentrated on conformance to the solicitation instructions, responsiveness to requirements, completeness, and clarity of content. If the solicitation response is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the solicitation response as non-conforming.

The ShareFile link for uploading Solicitation Response(s) is provided in the Schedule of Events, Section I.C.

Noted.

*****UNLESS OTHERWISE NOTED, DO NOT SUBMIT DOCUMENTS THAT CAN ONLY BE ACCESSED WITH A PASSWORD*****

1. Bidders must submit responses via ShareFile using the solicitation submission link.

Note: Not all browsers are compatible with ShareFile. Currently Google Chrome, Internet Explorer, Microsoft Edge, Safari, and Firefox are compatible. After the bidder clicks the solicitation response submission link, the bidder will be prompted to enter contact information including an e-mail address. By entering an e-mail address, the bidder should receive a confirmation email confirming the successful upload directly from ShareFile.

ShareFile link for uploading solicitation response(s) provided in the Schedule of Events, Section I.C.

- a. The Solicitation response and Proprietary information should be uploaded as separate and distinct files.
 - i. If duplicated responses are submitted, the State will retain only the most recently submitted response.
 - ii. If it is the bidder's intent to submit multiple responses, the bidder must clearly identify the

- separate submissions.
- iii. It is the bidder's responsibility to allow time for electronic uploading. All file uploads must be completed by the Opening date and time per the Schedule of Events. No late responses will be accepted.

b. ELECTRONIC SOLICITATION RESPONSE FILE NAMES

The bidder should clearly identify the uploaded solicitation response files. To assist in identification the bidder should use the following naming convention:

- i. 122436 O5 Company Name
If multiple files are submitted for one solicitation response, add number of files to file names:
122436 O5 Company Name File 1 of 2
122436 O5 Company Name File 2 of 2
- ii. If multiple responses are submitted for the same solicitation, add the response number to the file names:
122436 O5 Company Name Response 1 File 1 of 2

Noted.

The "Contractual Agreement Form" must be signed manually in ink or by DocuSign and returned by the opening date and time along with the bidder's solicitation response and any other requirements as stated in this solicitation in order for the bidder's solicitation response to be evaluated.

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing.

Noted.

J. SOLICITATION PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidder's in replying to this solicitation, including any activity related to bidding on this solicitation.

Noted.

K. FAILURE TO COMPLY WITH SOLICITATION

Violation of the terms and conditions contained in this solicitation or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's solicitation response,
2. Withdrawal of the Intent to Award,
3. Withdrawal of the Award,
4. Negative documentation regarding Vendor Performance,
5. Termination of the resulting contract,
6. Legal action; and
7. Suspension or Debarment of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation. Such period to be within the sole discretion of the State.

Noted.

L. SOLICITATION RESPONSE CORRECTIONS

A bidder may correct a mistake in an electronically submitted solicitation response prior to the time of opening by uploading a revised and completed solicitation response.

1. If a corrected electronic solicitation response is submitted, the file name(s) date/time stamped with latest date/time stamp will be accepted. The corrected solicitation response file name(s) should be identified as:
 - a. Corrected 122436 O5 Company Name Response #1 File 1 of 2,
 - b. Corrected 122436 O5 Company Name Response #2 File 2 of 2, etc.

Changing a solicitation response after opening may be permitted if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

Noted.

M. LATE SOLICITATION RESPONSES

Solicitation Responses received after the time and date of the opening will be considered late responses. Late

responses will be considered non-responsive. The State is not responsible for responses that are late or lost regardless of cause or fault.

Noted.

N. BID OPENING

The opening will consist of opening solicitation responses and announcing the names of bidders. Responses **WILL NOT** be available for viewing by those present at the opening. Responses will be posted to the State Purchasing Bureau website once an Intent to Award has been posted to the website. Once responses are opened, they become the property of the State of Nebraska and will not be returned.

Noted.

O. SOLICITATION REQUIREMENTS

The solicitation responses will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Solicitation responses not meeting the requirements may be rejected as non-responsive. The requirements are as follows:

1. Original Contractual Agreement Form signed manually in ink or by DocuSign;
2. Clarity and responsiveness;
3. Completed Corporate Overview;
4. Completed Sections II through IV;
5. Completed Technical Response, including Attachment C - Confirmations & Questionnaire;
6. Completed Attachment A - Intent to Propose Form;
7. Completed Attachment B - Business Associate Agreement;
8. Completed Attachment D - Performance Guarantee Sheet; and
9. Completed Cost Sheet.

Noted.

P. EVALUATION COMMITTEE

Solicitation Responses are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this Solicitation may result in the rejection of this response and further administrative actions.

Noted.

Q. EVALUATION OF SOLICITATION RESPONSES

All solicitation responses that are deemed responsive to the solicitation will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all responses in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview may include, but is not limited to:

- a. the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Solicitation;
- b. the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- c. whether the bidder can perform the contract within the specified time frame;
- d. the bidder's historical or current performance; and
- e. such other information that may be secured and that has a bearing on the decision to award the contract.

In evaluating the corporate overview, the State may consider, past experiences with the vendor, references, the State's record of the vendor which may include, but is not limited to Vendor Compliance Request, Contract Non-Compliance Notice, vendor performance reports, and any information related to the vendor's historical or current character, integrity, reputation, capability, or performance with the State or a third-party.

2. Technical Response; and

3. Cost Sheet.

Neb. Rev. Stat. § 73-808 allows the State to consider a variety of factors, including, but not limited to, the quality of performance of previous contracts to be considered when evaluating responses to competitive solicitations in determining a responsible bidder. Information obtained from any Contract Compliance Request or any Contract Non-Compliance Notice (See Terms & Conditions, Section H) may be used in evaluating responses to solicitations for goods and services to determine the best value for the State.

Neb. Rev. Stat. § 73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a

disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in (a) of this paragraph and (ii) the management and daily business operations of the business are controlled by one or more persons described in (a) of this paragraph. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a solicitation response in accordance with Neb. Rev. Stat. § 73-107 and has so indicated on the Contractual Agreement Form under "Vendor must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the Vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service,
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions),
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Noted.

R. BEST AND FINAL OFFER

Each bidder should provide its best offer with their original solicitation response and should not expect the State to request a best and final offer (BAFO).

The State reserves the right to conduct more than one BAFO. If requested by the State, the BAFO must be submitted on the BAFO Cost Sheet and in accordance with the State's instructions. Failure to submit a requested BAFO or failure to submit a BAFO in accordance with the State's instructions may result in rejection of the bidder's entire solicitation response. BAFOs may be scored and ranked by the Evaluation Committee.

Noted.

S. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a solicitation response, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a solicitation response, withdraw an intent to award, or rescind the award of a contract.

Noted.

T. AWARD

The State reserves the right to evaluate solicitation responses and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the solicitation responses, or at any point in the Solicitation process, the State of Nebraska may take one or more of the following actions:

1. Amend the solicitation;
2. Extend the date and time of a solicitation;
3. Waive deviations or errors in the State's solicitation process and in bidder responses that are not material, do not compromise the solicitation process or a bidder's response, and do not improve a Vendor's competitive position;
4. Accept or reject a portion of or all of a solicitation response;
5. Accept or reject all responses;
6. Withdraw the solicitation;
7. Elect to re-release the solicitation;
8. Award single lines or multiple lines to one or more Vendors; or,
9. Award one or more all-inclusive contracts.

The solicitation does not commit the State to award a contract. Once intent to award decision has been determined,

it will be posted to the Internet at: <https://das.nebraska.gov/materiel/bidopps.html>

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted to the Internet. Grievance and protest procedure is available on the Internet at: https://das.nebraska.gov/materiel/docs/NE_DAS_Materiel_Purchasing_Agency-SPB_Policy_23_07_Protest_Policy.pdf

Noted.

U. LUMP SUM OR “ALL OR NONE” SOLICITATION RESPONSES

The State reserves the right to purchase item-by-item, by groups or as a total when the State may benefit by so doing. Bidders may submit a response on an “all or none” or “lump sum” basis but should also submit a response on an item-by-item basis. The term “all or none” means a conditional response which requires the purchase of all items on which responses are offered and bidder declines to accept award on individual items; a “lump sum” response is one in which the bidder offers a lower price than the sum of the individual responses if all items are purchased but agrees to deliver individual items at the prices quoted.

“LUMP SUM” OR “ALL OR NONE” RESPONSES SHOULD BE CLEARLY IDENTIFIED ON THE FIRST PAGE OF THE SOLICITATION AND COST SHEET (IF APPLICABLE)

Noted.

V. REJECTION OF SOLICITATION RESPONSES

The State reserves the right to reject any or all responses, wholly or in part, in the best interest of the State.

Noted.

W. PRICES & COST CLARIFICATION

Discount and Price provisions are discussed in Sections III.F. and III.G. The State reserves the right to review all aspects of cost for reasonableness and realism as those terms are defined in (Neb. Rev. Stat. § 73-810 (1) (a) and (b) The State may request clarification of any solicitation where the cost component indicates a significant and unsupported deviation from industry standards or in areas where detailed pricing is required. Under Neb. Rev. Stat. § 73-810 (2), the State may reject a bid if the price is not reasonable or realistic.

Noted.

X. VENDOR DEMONSTRATIONS

The State may determine that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Corporate Overview, Technical Response, and Cost Sheets. The presentation process will allow the bidders to demonstrate their solicitation response offering, explaining and/or clarifying any unusual or significant elements related to their solicitation responses. Bidders' key personnel, identified in their solicitation response, may be requested to participate in a structured interview to determine their understanding of the requirements of this solicitation response, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their solicitation responses.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the solicitation responses received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

Noted.

II. TERMS AND CONDITIONS

Bidder should read the Terms and Conditions within this section and must initial either “Accept All Terms and Conditions Within Section as Written” or “Exceptions Taken to Terms and Conditions Within Section as Written” in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the “Exceptions” field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder’s commercial contracts and/or documents for this solicitation.

Accept All Terms and Conditions Within Section as Written (Initial)	Exceptions Taken to Terms and Conditions Within Section as Written (Initial)	Exceptions: (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	<i>RB</i>	Section T. Early Termination Not confirmed. Early termination penalties apply, as follows: 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.

The bidders should submit with their solicitation response any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the solicitation response as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

Please refer to “122436 O5 UnitedHealthcare Pharmacy - TX - UHS TPA Perpetual” and “122436 O5 UnitedHealthcare Pharmacy - Sample ASA” provided with our proposal response.

We require the self-funded customer to sign the administrative services agreement (ASA) that will outline and define the services that we provide. We encourage our self-funded customers to use and sign our standard ASA, which includes our HIPAA business associate agreement (BAA). The ASA reflects the material terms of the proposal and is the final understanding and agreement between the parties. During our administration of the plan, there may be other agreements that arise which may need to be executed by the customer, including but not limited to, benefit exceptions and/or settlement agreements for matters concerning specific members.

If a conflict or ambiguity arises after the Addendum to Contract Award has been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one (1) Party has a particular clause, then that clause shall control,
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together,
3. If both Parties have a similar clause, but the clauses conflict, the State’s clause shall control.

Agreed.

A. GENERAL

1. The contract resulting from this Solicitation shall incorporate the following documents:

- a. Solicitation, including any attachments and addenda;
- b. Questions and Answers;
- c. Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder;
- d. Addendum to Contract Award (if applicable); and
- e. Amendments to the Contract. (if applicable)

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.

Unless otherwise specifically agreed to in writing by the State, the State's standard terms and conditions, as executed by the State, shall always control over any terms and conditions or agreements submitted or included by the Vendor.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Agreed.

B. NOTIFICATION

Bidder and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally; electronically, return receipt requested; or mailed, return receipt requested. All notices, requests, or communications shall be deemed effective upon receipt.

Either party may change its address for notification purposes by giving notice of the change and setting forth the new address and an effective date.

Confirmed. We are naming Jelena Edwards, Strategic Account Executive and Jessica Czajka, OptumRx Regional Account Executive.

C. BUYER'S REPRESENTATIVE

The State reserves the right to appoint a Buyer's Representative to manage or assist the Buyer in managing the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the bidder will be provided a copy of the appointment document and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

Noted.

D. GOVERNING LAW (Nonnegotiable)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

Agreed.

E. BEGINNING OF WORK & SUSPENSION OF SERVICES

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin.

The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.

We do not anticipate work stoppages that would affect the provision of the products or services included in our proposal; however, in the unlikely event there is a work stoppage due to a disaster, we are fully prepared with appropriate business continuity plans.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties.

Agreed.

G. CHANGE ORDERS OR SUBSTITUTIONS

The State and the Vendor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes.

The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance.

No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price.

*****Vendor will not substitute any item that has been awarded without prior written approval of SPB*****

This is not applicable to the services we are proposing. Correction or reperformance of services under warranty requirements are typically specific to companies that provide tangible goods and materials or construction companies. Our agreements are not traditional goods agreements and are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

H. RECORD OF VENDOR PERFORMANCE

The State may document the vendor's performance, which may include, but is not limited to, the customer service provided by the vendor, the ability of the vendor, the skill of the vendor, and any instance(s) of products or services delivered or performed which fail to meet the terms of the purchase order, contract, and/or specifications. In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for a specific contract ("Contract Compliance Request"). The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request. At the sole discretion of the State, such Contract Compliance Requests and Contract Non-Compliance Notices may be placed in the State's records regarding the vendor and may be considered by the State and held against the vendor in any future contract or award opportunity. The record of vendor performance will be considered in any suspension or debarment action.

Noted.

I. NOTICE OF POTENTIAL VENDOR BREACH

If Vendor breaches the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

Noted.

J. BREACH

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time.

The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies.

In addition, this contract will terminate under the following circumstances if the State fails to cure the breach within the timeframe provided in this Section, after receiving written notice of such breach from Contractor, delivered by email, delivery receipt request; certified or registered mail, return receipt requested, postage prepaid, or delivered by a service that provides written receipt of delivery.: (i) the State fails to provide the required funds for payment of benefits under the terms of this contract, and the State fails to cure such breach within five (5) days of receipt of notice of termination, or (iii) the State

fails to cure a breach within thirty (30) of Contractor notifying the State of termination because the State is in material breach of this contract, other than for the funding of Plan benefits, and does not correct the breach within thirty (30) days of receipt of notice of termination.

K. NON-WAIVER OF BREACH

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

Noted.

L. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

Agreed.

M. INDEMNIFICATION

1. GENERAL

The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"),

sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Vendor has indemnified the State, the Vendor shall, at the Vendor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Vendor, and the State may receive the remedies provided under this Solicitation.

3. PERSONNEL

The Vendor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Vendor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01. If there is a presumed loss under the provisions of this agreement, Vendor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,239.01 to 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Neb. Rev. Stat. § 81-8,294), Tort (Neb. Rev. Stat. § 81-8,209), and Contract Claim Acts (Neb. Rev. Stat. § 81-8,302), as outlined in state law and accepts liability under this agreement only to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

Agreed, to entire section.

N. ATTORNEY'S FEES

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

The employer remains responsible for payment of benefit claims. As a result, the employer may exercise their discretion to settle such litigation. Any claim for indemnification of legal fees is subject to all terms of the indemnification provision of the self-funded agreement.

O. PERFORMANCE BOND

The Awarded Bidder will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be \$2 million. The bond will guarantee that the Awarded Bidder will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the contract has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

We are prepared to provide a surety bond if required. A copy of the contract must be reviewed by our bond broker and we will typically use their preferred bond form.

P. ASSIGNMENT, SALE, OR MERGER

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

Noted.

Q. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUBDIVISIONS OF THE STATE OR ANOTHER STATE

The Vendor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. § 81-145(2), to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Vendor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Noted.

R. FORCE MAJEURE

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed. The Party so affected shall immediately make a written request for relief to the other Party and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

Noted.

S. CONFIDENTIALITY

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.

Noted.

T. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time.
2. The State, in its sole discretion, may terminate the contract, in whole or in part, for any reason upon thirty (30) calendar day's written notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery to the Vendor. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the contract, in whole or in part, immediately for the following reasons:
 - a. if directed to do so by statute,
 - b. Vendor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business,
 - c. a trustee or receiver of the Vendor or of any substantial part of the Vendor's assets has been appointed by a court,
 - d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Vendor, its employees, officers, directors, or shareholders,
 - e. an involuntary proceeding has been commenced by any Party against the Vendor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Vendor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Vendor has been decreed or adjudged a debtor,

- f. a voluntary petition has been filed by the Vendor under any of the chapters of Title 11 of the United States Code,
- g. Vendor intentionally discloses confidential information,
- h. Vendor has or announces it will discontinue support of the deliverable; and,
- i. In the event funding is no longer available.

Any early termination provision contained in the vendor's contract cannot be tied to financial provisions or penalties.

Not confirmed. Early termination penalties apply, as follows: 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.

In addition, this contract will terminate under the following circumstances: (i) Contractor gives the State notice of termination because the State did not pay the fees or other amounts owed Contractor when due under the terms of the contract, (ii) the State fails to provide the required funds for payment of benefits under the terms of this contract, or (iii) the State is in material breach of this contract, other than by non-payment or late payment of fees owed by the State or the funding of Plan benefits, and does not correct the breach within thirty (30) days after being notified in writing.

U. CONTRACT CLOSEOUT

Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State,
2. Transfer ownership and title to all completed or partially completed deliverables to the State,
3. Return to the State all information and data unless the Vendor is permitted to keep the information or data by contract or rule of law. Vendor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Vendor's routine back up procedures,

To address items 1-3 above, United proposes the following since there are no deliverables under this arrangement that would be transferred to the State: *Contractor will keep records relating to the services provided for as long as Contractor is required to do so by law. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;*

4. Cooperate with any successor Contactor, person, or entity in the assumption of any or all of the obligations of this contract,
5. Cooperate with any successor Contactor, person, or entity with the transfer of information or data related to this contract,
6. Provide any successor Contactor, person, or entity with historical data. Transition of data will begin immediately following notification of termination and must be complete within 90 days of that notification,
7. Return or vacate any state owned real or personal property; and,
8. Return all data in a mutually acceptable format and manner.

Nothing in this section should be construed to require the Vendor to surrender intellectual property, real or personal property, or information or data owned by the Vendor for which the State has no legal claim.

We would return data, if feasible. United may be required to maintain data in accordance with its legal obligations.

V. AMERICANS WITH DISABILITIES ACT

Vendor shall comply with all applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131–12134), as amended by the ADA Amendments Act of 2008 (ADA Amendments Act) (Pub.L. 110–325, 122 Stat. 3553 (2008)), which prohibits discrimination on the basis of disability by public entities.

Noted.

III. VENDOR DUTIES

Bidder should read the Vendor Duties within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Vendor Duties Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Vendor Duties Within Section as Written (Initial)	Exceptions Taken to Vendor Duties Within Section as Written (Initial)	Exceptions: (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	RB	Our organization leverages external third-party subcontractors to augment our operations and service offerings, when/where appropriate. We have programs in place to assure that these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements. We will be responsible for services provided by our subcontractors to the same extent that we would have been had we performed those services without the use of a subcontractor. We are unable to agree to include those exact provisions without modifications in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been had we performed those services without the use of a subcontractor.
	RB	We have included necessary deviations to the specific requirements in J. Insurance Requirements below.

A. INDEPENDENT VENDOR / OBLIGATIONS

It is agreed that the Vendor is an independent Vendor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

Noted.

The Vendor is solely responsible for fulfilling the contract. The Vendor or the Vendor's representative shall be the sole point of contact regarding all contractual matters.

Noted. For questions of a general nature, the contact person will be Jelena Edwards, Account Executive. Jelena will reach out to others within the organization for assistance, as appropriate.

The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Vendor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

Noted.

By-name personnel commitments made in the bidder's solicitation response shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Vendor to the contract shall be employees of the Vendor or a subcontractor and shall be fully qualified to perform the work required herein. Personnel employed by the Vendor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Vendor or the subcontractor respectively.

With respect to its employees, the Vendor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding,

Agreed.

2. Any and all vehicles used by the Vendor's employees, including all insurance required by state law,

Agreed.

3. Damages incurred by Vendor's employees within the scope of their duties under the contract,

Agreed.

4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law,

Agreed.

5. Determining the hours to be worked and the duties to be performed by the Vendor's employees; and,

6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Vendor, its officers, agents, or subcontractors or subcontractor's employees).

Our organization leverages external third-party suppliers (subcontractors) to augment our operations and service offers, when/where appropriate. We have programs in place to ensure these partners meet relevant performance, operational and contractual/compliance

If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the solicitation response. The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the Vendor's agreement with the respective subcontractor(s).

Our organization leverages external third-party subcontractors to augment our operations and service offerings, when/where appropriate. We have programs in place to assure that these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements. We will be responsible for services provided by our subcontractors to the same extent that we would have been had we performed those services without the use of a subcontractor.

The State reserves the right to require the Vendor to reassign or remove from the project any Vendor or subcontractor employee.

Noted.

Vendor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

Noted.

The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

We are unable to agree to include those exact provisions without modifications in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been had we performed those services without the use of a subcontractor.

B. FOREIGN ADVERSARY CONTRACTING PROHIBITION ACT CERTIFICATION (Nonnegotiable)

The Vendor certifies that it is not a scrutinized company as defined under the Foreign Adversary Contracting Prohibition Act, Neb. Rev. Stat. Sec. § 73-903 (5); that it will not subcontract with any scrutinized company for any aspect of performance of the contemplated contract; and that any products or services to be provided do not originate with a scrutinized company.

Noted.

C. EMPLOYEE WORK ELIGIBILITY STATUS

The Vendor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Vendor is an individual or sole proprietorship, the following applies:

1. The Vendor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at <https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf>
2. The completed United States Attestation Form should be submitted with the Solicitation response.
3. If the Vendor indicates on such attestation form that he or she is a qualified alien, the Vendor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Vendor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Vendor understands and agrees that lawful presence in the United States is required, and the Vendor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

Noted.

D. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Nonnegotiable)

The Vendor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Vendors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Vendor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Vendor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this Solicitation.

Noted.

E. COOPERATION WITH OTHER VENDORS

Vendor may be required to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. The Vendor shall agree to cooperate with such other Vendors or individuals and shall not commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.

Noted.

F. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

Not applicable to the products we are quoting.

G. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Confirmed.

Prices submitted on the cost sheet, once accepted by the State, shall remain fixed for the first three (3) years of the contract. Any request for a price increase subsequent to the initial three (3) years of the contract shall not exceed 3.5% of the price proposed for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the State Purchasing Bureau a minimum of 180 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase.

Not confirmed.

Vendor agrees there are NO additional fees (beyond those outlined in the Cost Sheet) required to provide the services outlined in this RFP. Any mandatory fees must be clearly outlined in the Cost Sheet. Under no circumstances will the State be liable to Vendor for fees not disclosed in Vendor's written proposal.

Confirmed. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

H. PERMITS, REGULATIONS, LAWS

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Vendor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Vendor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

Noted.

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Vendor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

United proposes the following to clarify ownership of information and data:

OWNERSHIP OF INFORMATION AND DATA I DELIVERABLES The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by Contractor on behalf of the State pursuant to this contract, except the State shall withhold proprietary business information of Contractor that would serve no public purpose if such information is not required to be disclosed pursuant to law. Specifically information and/or data that contains Contractor proprietary business information (e.g., reasonable & customary amounts, network discounts, reimbursement methodologies); we have proprietary business rights to that information and/or data. All eligibility records are the sole property of the State, and shall be made available upon request to the State and its representatives. Within a

reasonable time frame Contractor will make available to the State or its representatives relevant information (e.g., eligibility and claim records) reasonably necessary for the State to perform planning, administration, audit and financial functions, except as may be prohibited by law or by third-party contract, provided there are appropriate confidentiality and hold harmless agreements in place. Selling of the State's data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the State. Even if Contractor has not "sold" the data, they are NOT free to use the data for analyses that they publish or provide at a fee to outside industries. UnitedHealthcare shall not use the State's data for any purpose other than for providing services for the State of Nebraska, except that UnitedHealthcare may use de-identified data in accordance with HIPAA standards for research, creation of comparative databases, or statistical analysis, or other studies. The State shall own and hold exclusive title to any deliverable developed as a result of this contract, except the state shall not own and hold exclusive title to Contractor's proprietary business information. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable. UnitedHealthcare does not anticipate creating works or inventions (e.g., design, specifications, concept or deliverables) on behalf of this specific customer. UHC services are universally provided to our entire book of business, and are not created through a means that would pass ownership interest or title to any one customer. The State needs to be able to acquire State records, regardless of the reason the State needs or wants them, without additional cost to the State.

J. INSURANCE REQUIREMENTS

The Vendor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Vendor shall not commence work on the contract until the insurance is in place. If Vendor subcontracts any portion of the Contract the Vendor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor,
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

Please refer to "122436 O5 UnitedHealthcare Pharmacy - UHG Blanket Crime 25-26" and "122436 O5 UnitedHealthcare Pharmacy - 25-26 UHG Blanket COI" provided with our proposal response.

Subcontractors are not named as insureds under our policy. However, we require our subcontractors to maintain adequate levels of insurance and we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder.

Noted. We require our subcontractors to maintain adequate levels of insurance and we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within three (3) years of termination or expiration of the contract, the Vendor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and three (3) years following termination or expiration of the contract.

We agree to maintain claims-made policies for a minimum period of three years after the termination of the agreement

If by the terms of any insurance a mandatory deductible is required, or if the Vendor elects to increase the mandatory deductible amount, the Vendor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Noted.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. WORKERS' COMPENSATION INSURANCE

The Vendor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Vendor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter.** The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

We maintain workers' compensation coverage with the statutory limits. We agree that our workers' compensation policies provide a waiver of subrogation in favor of the customer, when required by a written contract, executed prior to a loss.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Vendors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

We carry commercial general liability coverage in the amounts required. We maintain automobile liability insurance in the amounts required. We agree to add the customer as an additional insured on our general liability and automobile liability policies where required by contract. We agree that our general liability and auto liability policies will be primary and non-contributory to the State's policies, if the State is included as an additional insured on such policies.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	\$2,000,000
Products/Completed Operations Aggregate	\$2,000,000
Personal/Advertising Injury	\$1,000,000 per occurrence
Bodily Injury/Property Damage	\$1,000,000 per occurrence
Medical Payments	\$10,000 any one person
Damage to Rented Premises (Fire)	\$300,000 each occurrence
Contractual	Included
Independent Vendors	Included
Abuse & Molestation	Included
<i>If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.</i>	
WORKER'S COMPENSATION	
Employers Liability Limits	\$500K/\$500K/\$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	\$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	\$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
Professional liability (Medical Malpractice)	~~\$40-5~~ ,000,000 per ~~occurrence~~ -claim
Qualification Under Nebraska Excess Fund	~~\$20-5~~ ,000,000 Aggregate
All Other Professional Liability (Errors & Omissions)	\$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	\$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	\$10,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

Please see our deviations in blue above.

3. EVIDENCE OF COVERAGE

The Vendor shall furnish the Contract Manager, via email, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

122436 O5
Department of Administrative Services
State Purchasing Bureau
Attn: Brook Taylor
1526 K Street, Suite 130
Lincoln, NE 68508
as.materielpurchasing@nebraska.gov

Noted.

These certificates or the cover sheet shall reference the solicitation number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Vendor to maintain such insurance, then the Vendor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

Noted.

4. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Vendor.

Please see our deviations above.

K. ANTITRUST

The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

Confirmed.

L. CONFLICT OF INTEREST

By submitting a solicitation response, vendor certifies that no relationship exists between the vendor and any person or entity which either is, or gives the appearance of, a conflict of interest related to this solicitation or project.

Vendor further certifies that vendor will not employ any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, vendor shall provide with its solicitation response a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall solicitation response evaluation.

Noted.

M. SITE RULES AND REGULATIONS

The Vendor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Vendor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Vendor.

We assume the customer's corporate policies are similar to ours, and we require our employees to abide by such similar standards. We agree to be bound by the customer's right to deny our employees access if the customer feels their policies or procedures have been violated. We request that customers notify us of such policies prior to our engagement and will work with the customer to understand applicable policies.

N. ADVERTISING

The Vendor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

Noted.

O. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Nonnegotiable)

1. The State of Nebraska is committed to ensuring that all information and communication technology (ICT), developed, leased, or owned by the State of Nebraska, affords equivalent access to employees, program participants and members of the public with disabilities, as it affords to employees, program participants and members of the public who are not persons with disabilities.
2. By entering into this Contract, Vendor understands and agrees that if the Vendor is providing a product or service that contains ICT, as defined in subsection 3 below and such ICT is intended to be directly interacted with by the user or is public facing, such ICT must provide equivalent access, or be modified during implementation to afford equivalent access, to employees, program participants, and members of the public who have and who do not have disabilities. The Vendor may comply with this section by complying with Section 508 of the Rehabilitation Act of 1973, as amended, and its implementing standards adopted and

promulgated by the U.S. Access Board.

3. ICT means information technology and other equipment, systems, technologies, or processes, for which the principal function is the creation, manipulation, storage, display, receipt, or transmission of electronic data and information, as well as any associated content. Vendor hereby agrees ICT includes computers and peripheral equipment, information kiosks and transaction machines, telecommunications equipment, customer premises equipment, multifunction office machines, software, applications, web sites, videos, and electronic documents. For the purposes of these assurances, ICT does not include ICT that is used exclusively by a Vendor.

For the questions above, please refer to “122436 O5 UnitedHealthcare Pharmacy - ACOE Summary” provided with our proposal response.

P. DISASTER RECOVERY/BACK UP PLAN

The Vendor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

Confirmed.

Q. DRUG POLICY

Vendor certifies it maintains a drug free workplace environment to ensure worker safety and workplace integrity. Vendor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Noted.

R. WARRANTY

Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

This is not applicable to the services we are proposing. Correction or reperformance of services under warranty requirements are typically specific to companies that provide tangible goods and materials or construction companies. Our agreements are not traditional goods agreements and are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

S. TIME IS OF THE ESSENCE

Time is of the essence with respect to Vendor's performance and deliverables pursuant to this Contract.

Noted.

T. BUSINESS ASSOCIATE AGREEMENT(BAA)

Bidder will execute and be in full compliance with Attachment XX Business Associate Agreement (BAA) with the State. Contractor acknowledges that it is compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA") and will execute the appropriate Business Associate Agreement ("BAA") as provided by the State.

Bidder will execute (without modification) and remain in full compliance with the attached BAA with the State.

United accepts the Business Associate Agreement (BAA) but would appreciate the opportunity to further discuss to make sure we can operationalize it properly.

IV. PAYMENT

Bidder should read the Payment clauses within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Payment clauses Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Payment Clauses Within Section as Written (Initial)	Exceptions Taken to Payment Clauses Within Section as Written (Initial)	Exceptions: (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
RB		

A. PROHIBITION AGAINST ADVANCE PAYMENT (Nonnegotiable)

Pursuant to Neb. Rev. Stat. § 81-2403, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

Noted.

B. TAXES (Nonnegotiable)

The State is not required to pay taxes and assumes no such liability as a result of this Solicitation. The Vendor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Vendor's equipment which may be installed in a state-owned facility is the responsibility of the Vendor.

Noted.

C. INVOICES

Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment, including detailed disclosure of all invoice line items to the State and should not include Personal Health Information (PHI). Vendor agrees that all reporting submitted by Vendor must be reconciled to the billing. The information on where to submit invoices will be provided to the awarded bidder upon contract finalization.

The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract. **The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State.**

Noted.

D. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State

officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Vendor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

Noted.

E. PAYMENT (Nonnegotiable)

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2403). The State may require the Vendor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Vendor prior to the Effective Date of the contract, and the Vendor hereby waives any claim or cause of action for any such goods or services.

Noted.

F. LATE PAYMENT (Nonnegotiable)

The Vendor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408).

Noted.

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Nonnegotiable)

The State's obligation to pay amounts due on the Contract for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Vendor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Vendor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Vendor be paid for a loss of anticipated profit.

Noted.

H. RIGHT TO AUDIT (First Paragraph is Nonnegotiable)

The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one (1) % of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or condition found as a result of the audit.

United HealthCare will begin the process of the audit (preparation, etc.) within 30 days. The State must advise United in writing of its intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by United.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Solicitation.

A. PROJECT OVERVIEW

The State of Nebraska ("State") employs approximately 17,500 individuals and 13,600 are enrolled in health plans. Enrolled members include active employees, pre-65 retirees, COBRA participants, and their dependents. Members are primarily located throughout the State of Nebraska. The State allows both Union and non-Union employees to be enrolled in one of the three (3) State health plans. The State currently has the following self-insured medical and prescription drug plans:

- Regular Plan
- Consumer Focused Health Plan (with Health Savings Account Eligibility)
- WellNebraska (with or without incentive)

The State's objective is to secure competitive and transparent pricing for pharmacy benefit management (PBM) services while maintaining and enhancing the quality of the pharmacy benefit plan and maximizing employee satisfaction. The State also seeks clinical and utilization management programs that will effectively reduce costs and waste while ensuring the highest standard of patient care.

The State currently has Contract 89546 O4 for Administrative and Support Services for the State of Nebraska Employee Health Care Benefits and Pharmacy Benefit Plans. This includes the administration of the Health Savings Account program and a Specialty Pharmacy Program.

Information about the current health plans offered to plan members is available at:

<http://das.nebraska.gov/benefits.html>

Health Plans (Plan Options: Regular, Consumer Focused, and WellNebraska) can be found at:

<https://das.nebraska.gov/personnel/wellness/health-and-prescription-benefits.html>

The State's Plan Year runs from July 1 to June 30. Note that it is the expectation of the State that work on this contract will begin immediately upon award, with a focus on implementation and Open Enrollment (OE) support (i.e., development of OE documents).

PBM Fees will not be paid until the benefit plan year begins on July 1, 2026.

Noted.

B. ENROLLMENT

The following is a table representing State active employees, pre-65 retirees, COBRA participants, and their dependents participation in each health plan by tier, as of February 2025. This may not be an exact match to the Census Data:

Plan/Tier	Regular PPO	Wellness PPO with incentive	Consumer Focused Health Plan (HDHP)	Wellness without Incentive	Total
Employee Only	1,079	4,289	1,137	306	6,811
Employee/Spouse	345	1,400	193	74	2,012
Employee/Child(ren)	227	1,432	193	86	1,938
Family	293	2,136	286	171	2,886
Total	1,944	9,257	1,809	637	13,647

Noted.

C. PROJECT OBJECTIVES

The State of Nebraska is looking to provide high quality, cost-effective benefits to its active employees, pre-65 retirees, COBRA participants, and their dependents. The State is soliciting offers for the administration of its self-insured

prescription drug plan.

Bidders are required to offer comprehensive PBM services with a full range of customer (client and member) services including, but not limited to:

1. Claims Adjudication
2. Member Enrollment and Eligibility Maintenance
3. ID Card Production and Distribution
4. Formulary Management and Rebate Pass-Through
5. Clinical and Utilization Management
6. Retail Pharmacy Network Management
7. Specialty and Mail Order Pharmacy
8. Patient and Provider Education
9. Systematic Prospective, Concurrent and Retroactive Drug Utilization Review
10. Auditing Rights
11. Account Management Services (including standard/custom reporting and online systems)
12. Member Services (including call center, website portal and mobile app)
13. Claims data sharing with State, healthcare and data analytics vendors

Please note that the State is concurrently conducting a procurement for medical administration services. This RFP is only for PBM services, and any information provided by respondents which pertains to the medical administration RFP or any other service (unless explicitly requested within the RFP), will not be considered in evaluation of this RFP. This includes attempts by Bidders to provide PBM fees that are contingent upon the additional award of business in connection with the medical administration RFP.

Noted.

D. SUBROGATION REQUIREMENT

Contractor shall enforce the State's right to seek recovery based on subrogation or other theories from third parties, or other insurance carriers, who have caused injury or illness to a covered person or damages to the plan, except when said third party is the State of Nebraska. Contractor shall provide subrogation recovery service at no additional charge to the State. Contractor may engage a subcontractor to perform specialized services for recovery of funds or discovery of overpayment or fraud. If any subrogation services are subcontracted by contractor, approval of subcontractors and contract terms must be obtained from the State prior to contractor entering into an agreement with any such subcontractor(s). Such subcontractors may be reimbursed based on a reasonable basis other than percent of recovery, but cost of such subcontractors shall be the responsibility of Contractor and shall not be deducted from the subrogated amount. The Contractor shall obtain the approval of the State for any subrogation claim that is less than 100% of the State's loss and shall obtain the State's approval of all settlements. In the event that the State is a party to litigation regarding any such claims, settlement or release of such claims must be approved by the State. This authority regarding recoveries from third parties or their carriers includes participation in consolidated or class action lawsuits alleging such injuries, if authorized by the State. Any recovery from consolidated or class action suits will be apportioned among all insured and self-insured plans or pools in like manner. The proration may be based on number of covered persons, number of injured persons, claims volume, or any other basis determined by contractor and approved by the State. Recoveries made in the same plan year as the original claim payments are made, will be applied to the State's claims liability by immediate credit to the State. Recoveries made in subsequent years will be credited in total to the State's claim liability at the time recovery is made. The State agrees to cooperate with all such recovery efforts.

Noted.

E. PRESCRIPTION DRUG PLAN DESIGN

At a minimum, the Contractor must duplicate the plan designs and level of coverage presently offered to the State's covered member population.

Noted.

F. PLAN REQUIREMENTS

The Contractor must adhere to the following Plan Requirements. These requirements will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State.

1. Provide services to all members (active employees, pre-65 retirees, COBRA participants, and their dependents) enrolled on the program effective date.

Noted.

2. Agree that members who are not actively at work due to disablement on program effective date will be covered.

Noted.

3. Agree that the State owns its data (its financial and operational data, and its member data), may use it for any business purposes it deems necessary, and that such data will be considered proprietary and will not be shared or utilized by Contractor for any purpose other than the provision of services under the agreement, except at the request of the State's Director of Administrative Services, and with full knowledge and express written consent.

Noted.

4. Acknowledges the State will neither recognize the appointment of any agent, general agent or broker nor authorize any payment or remuneration of any kind by the Contractor to a party not approved in writing by the State.

Noted.

5. Advise and assist the State in the preparation of forms and other documentation necessary to fulfill reporting and disclosure requirements.

We will provide administrative services consistent with the State's plan design(s) in accordance with the terms of our administrative services agreement (ASA) with you, and in accordance with all relevant laws and regulations. However, as the plan sponsor of your self-funded benefit plan, you retain ultimate responsibility for the legal sufficiency of your plan design and summary plan description (SPD) content, in accordance with applicable laws.

6. Agrees it will not render or administer services (including wellness) offshore, and all work performed will be in the contiguous United States.

Confirmed.

7. Comply with and adhere to relevant federal and state laws and regulations.

Noted.

8. Monitor Federal and State legislation affecting the plan and report to the State on those issues in a timely fashion and prior to the effective date of any mandated plan changes.

Our legal services staff maintains awareness of pertinent legal issues, decisions and rulings, and communicates updates to the relevant areas of our company, including a dedicated regulatory team. New laws affecting our business are disseminated to the relevant business areas of our company.

9. Assume responsibility for any and all costs associated with any investigation necessary to ensure that claims are adjudicated properly.

Agreed.

10. Follow the specified eligibility rules established by the State.

Confirmed. Eligibility determinations are based on the eligibility information provided to us by the State. We assume you own your eligibility rules and verify eligibility under the plan.

11. Agree to all requirements as outlined in Attachment C - Confirmations & Questionnaire, Confirmations tab.

Not confirmed. We have provided additional information where we cannot agree.

12. Assign a dedicated Account Management Team (AMT) who shall be accountable and responsible to the State for proactive management of all aspects of the Contractor's performance to the State and its members. The Contractor shall not change assignment of the Account Executive on the AMT, without written notice provided to the State with a minimum of fourteen (14) business days prior to such change. The State reserves the right to request assignment of a new Account Executive, and the Contractor shall make such change within 30 calendar days of receipt of written notice from the State. A member of the AMT must respond to any outreach from the State of Nebraska within one (1) business day.

Noted.

13. Provide a mutually agreed upon annual score card so the State can assess Contractor's performance.

Noted.

14. Provide claim line detail for ALL claims as described in this RFP.

Noted.

15. Provide robust, accurate, timely, and comprehensive data and reporting to the State. The State and its healthcare consultants must have the ability to access a reporting portal to download all reports. This provision includes State specific utilization data for State members, upon request.

Online reports are available monthly through our employer portal, Employer eServices, and the data to support reports are updated on the 10th business day following the reporting month. You can initiate reporting requests at any time and review the reports online after allowing a momentary processing time.

16. Provide data feeds (ex. eligibility file) to the State's vendor partners, as requested. The cost for providing data feeds must be included in the Contractor's administrative fees. Contractor agrees to waive any charges to the State or the State's vendors such as a set-up fee, a programming fee or a monthly fee, for establishing a connection with a third party vendor for real-time, bidirectional data integration, including non-standard data integration formats.

Current data feeds will remain in place; however, UHC reserves the right to pass along the cost of future request. Pricing can be provided upon request.

17. The Contractor must perform and present to the State, on a quarterly or as requested basis, the State's current plans and service performance, recent issues/challenges encountered, potential savings opportunities, and topics of concern and suggestions for resolution, at no additional cost to the State.

Noted.

18. Attend an annual performance or "stewardship" meeting within 180 days after contract year-end at which time the Contractor will, as directed by the State, summarize activities and performance for the year ended.

Noted.

19. Participate in an Annual Vendor Summit to discuss strategic opportunities for the State's overall health management program.

Noted.

20. Provide final Summary Plan Documents (SPD), written and electronic, including SPD language for any clinical programs to be implemented, to the State prior to the initial Open Enrollment period and subsequent open enrollments. SPDs are subject to the final approval of the State.

Noted.

21. Agree to provide an opportunity for the State to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and/or to providers.

Noted.

22. Complete implementation prior to the State's Annual Open Enrollment period each May.

Noted.

23. Agree that no external communications material that mentions the State's benefit plans may be circulated without written approval from the State.
Confirmed.
24. Attend and participate in the annual Human Resource Information Group (HRIG) in April of each year. The Contractor may be asked to participate in the informational meetings across the State directly following the HRIG. If requested by other State agencies, the Contractor may participate in agency specific health fair(s).
Noted.
25. Offer a program to prevent and detect internal and external fraud and fraudulent practices.
Noted.
26. Administer run-out claims for 12 months following termination of the contract. The cost of run-out administration must be included in bidder's proposed administration fees.
Noted.
27. Provide complete banking arrangements for claims processing, including the printing and issuing of checks and/or electronic funds transfer.
Noted.
28. No covered State members shall lose or gain coverage as a result of vendor change. Any and all transition-of-care-related issues must be expressly waived for the initial enrollment for covered eligibles and their dependents that have already satisfied the limitations under the existing plan, unless otherwise specified in the eligibility rules established by the State.
Noted.
29. Complete formulary disruption and retail network disruption analyses as detailed in the Questionnaire.
Noted.
30. **Attachments:** Complete all RFP attachments:
 - a. Attachment A – Intent to Propose
 - b. Attachment B – Business Associate Agreement (BAA)
 - c. Attachment C – Confirmations & Questionnaire
 - i. Completed Formulary Disruption Analysis as requested in Questionnaire Tab D.3
 - ii. Completed Network Disruption Analysis as requested in Questionnaire Tab F.14
 - d. Attachment D – Performance Guarantees
 - e. Cost Sheet

Noted.

G. BUSINESS REQUIREMENTS

1. Contractor must be currently providing self-funded PBM administration services to at least one public sector group health plan with a minimum of 15,000 lives.
Noted.
2. Contractor must have a minimum of five (5) years of self-funded PBM administration group experience.
Noted.
3. Contractor must be licensed to offer employer-sponsored, network-based self-funded PBM plan solutions in all 50 states and U.S. territories where State members currently reside.

Confirmed. Please refer to “122436 O5 – UnitedHealthcare Pharmacy - TX - UHS TPA Perpetual” provided with our proposal response.

4. Contractor must not have any bankruptcy filings within the last 5 years; and Offeror's senior officers, board members, or directors must not have any felony convictions.

To the best of our knowledge, in the last five years, we have neither filed (or had filed against us) any voluntary or involuntary bankruptcy or insolvency proceeding, nor have we undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

To the best of our knowledge, none of our employees or subcontractors are felons who have been convicted of a crime related to the job they are hired to perform.

We perform background checks on potential employees prior to hiring them and, with discretion, throughout the course of employment.

In addition, we have an office of ethics and integrity that requires employees and contractors to report all suspected illegal or unethical conduct, including violations of law, contractual obligations and company policies or concerns about accounting, internal controls, auditing matters or suspected fraud and abuse.

If misconduct occurs, we investigate the matter, take disciplinary action, if necessary, and implement corrective measures to prevent future violations. We also have fidelity/crime insurance coverage, which protects our organization from losses arising from employee dishonesty, forgery, theft, robbery, burglary and fraud.

Furthermore, our procurement contract negotiators routinely include an exhibit attached to a master services agreement that addresses background checks for vendor personnel who require independent access to our information systems and/or physical facilities.

H. DELIVERABLES

Provide the following third-party administration services for the State's prescription drug coverage as listed in this RFP:

1. Claims Adjudication
2. Member Enrollment and Eligibility Maintenance
3. ID Card Production and Distribution
4. Formulary Management and Rebate Pass-Through
5. Clinical and Utilization Management
6. Retail Pharmacy Network Management
7. Specialty and Mail Order Pharmacy
8. Patient and Provider Education
9. Systematic Prospective, Concurrent and Retroactive Drug Utilization Review
10. Auditing Rights
11. Account Management Services (including standard/custom reporting and online systems)
12. Member Services (including call center, website portal and mobile app)
13. Claims data sharing with State, healthcare and data analytics vendors

Noted.

VI. SOLICITATION RESPONSE INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Corporate Overview and Technical Response portions of the solicitation response. The solicitation Cost Sheet template should be completed by bidders and submitted as a separate attachment with their solicitation response. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their solicitation response; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Solicitation responses are due by the date and time shown in the Schedule of Events. Content requirements for the Corporate Overview and, Technical Response are presented separately in the following subdivisions:

A. SOLICITATION RESPONSE SUBMISSION

1. CORPORATE OVERVIEW

The Corporate Overview section of the solicitation response should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, (including whether the Bidder is in good standing in the state in which it is formed or incorporated), year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized. The Bidder should also provide this information for the branch or local office or other subordinate element that will perform or assist in performing the work on this contract.

**United HealthCare Services, Inc.
9700 Health Care Lane
Minnetonka, Minnesota 55343**

**UnitedHealthcare is a corporation and one of the family of businesses that
comprise UnitedHealth Group.**

**United HealthCare Services, Inc. was incorporated in Minnesota on September
17, 1974.**

b. FINANCIAL STATEMENTS

The bidder should provide its organization's last audited financial statement and the most recent unaudited financial statement if the most recent audited financial statement is older than 12 months as well as the latest SSAE 21 report. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that solicitation evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

**Confirmed. Please refer to "122436 O5 UnitedHealthcare Pharmacy - Annual
Financial Report" provided with our proposal response.**

The State can access our latest SSAE 18 (SOC 1, Type II) reports on eServices.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the solicitation response due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

The bidder should state and describe if it recently experienced any workforce realignments and/or recent merger or acquisition activity. Include in this description, any anticipated changes in ownership or business developments, including but not limited to mergers, stock issues, and the acquisition of new venture capital.

There are no pending or anticipated ownership changes. As a public company, our shares trade every day, but the large owners have generally been stable and no one has purchased, or is expected to purchase, a 10% or greater position in the company.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

2717 N. 118th Street, Suite 300, Omaha, Nebraska 68164.

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous twelve (12) months. If the organization, its predecessor, or any Party named in the bidder's solicitation response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Contract# 744240 Medical/Carve-In Pharmacy 306147 – STD/LTD.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's solicitation response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for solicitation response submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this solicitation. If no such relationship exists, so declare.

There are no disclosed relationships with the State.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past (three) (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past (three) (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's solicitation response accordingly. If no such termination for default has been experienced by the bidder in the past (three) (3) years, so declare.

If at any time during the past (three) (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

To the best of our knowledge, we have not had a customer contract termination due to default, failure to complete or legal action.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this Solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the solicitation response.

The bidder should address the following:

- i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Solicitation. These descriptions should include:
 - a) The time period of the project,
 - b) The scheduled and actual completion dates,
 - c) The bidder's responsibilities,
 - d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
 - e) Each project description should identify whether the work was performed as the

prime Vendor or as a subcontractor. If a bidder performed as the prime Vendor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

- ii. Bidder and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as subcontractor projects.
- iii. If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

Please refer to “122436 O5 UnitedHealthcare Pharmacy - Summary of Bidders Experience” provided with our proposal response.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The State will continue to be supported by a multi-functional account management team (AMT), who is your point of contact for all aspects of administration, claims, underwriting, contracts, eligibility, billing and reporting and will work to meet your service needs. Essential roles include:

- **Jelena Edwards, Strategic Account Executive (SAE) – Customer relationship owner with overall responsibility of your account.**
- **Travis Granger, Implementation Manager (IM) – Manages/oversees the implementation process if plan changes are decided to be made.**

We recognize the State is a unique company with unique employees, and we believe the AMT structure outlined above offers functional expertise and excellence, while maintaining a customer focus.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface, and support functions, and reporting relationships. The primary work assigned to each person should also be identified. For each team member listed, identify whether this staff member will be 100% dedicated/designated to the State account. If the member is not 100% dedicated/designated to the State, please indicate the percentage of time the staff member will designate to the State account as well as the number of other clients with which the staff member has responsibilities. At a minimum, the specific professionals should include:

- a) Implementation Coordinator/Manager

Travis Granger, Implementation Manager (IM). Based on average workload, an IM spends between 8% to 20% of their time dedicated to a customer's needs.
- b) Account Executive

**Jessica Czajka, OptumRx Regional Account Executive
Jessica has 100 clients and will dedicate 15% to 20% of her time to the State.**
- c) Eligibility Coordinator/Manager

Janelle Lundin, Electronic Eligibility Analyst. Janelle works with 24 clients. Once each file comes in and is reviewed, Janelle will dedicate 100% of her time to the files.
- d) Pharmacist

Wayne Knisley, Pharmacist

Wayne has about 100 clients and will dedicate 5% to 10% of his time to the State.

e) Member Service Manager

EricaLee Fortner, UnitedHealthcare Service Account Manager, works with 5 clients and will spend 30% of her time dedicated to the State.

f) Government/Legislative Liaison

Wade Hapgood, Government/Legislative Liaison, is assigned to the states of Kansas, Nebraska and Montana. Engagement varies depending on the needs but time dedicated will be 33%.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Confirmed. Please refer to "122436 O5 UnitedHealthcare Pharmacy - Account Management Team Resumes and Bios" provided with our proposal response.

The bidder to note any positions bidder will need to hire if awarded this contract.

The bidder will provide an organization chart, including names and titles, of Account Team and key personnel that will be responsible for the State account.

Confirmed. Please refer to "122436 O5 UnitedHealthcare Pharmacy - State of Nebraska Organizational Chart" provided with our proposal response.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

- a) name, address, and telephone number of the subcontractor(s),
- b) specific tasks/types of services provided for each subcontractor(s),
- c) number of years the Bidder's company has utilized the subcontractor,
- d) contractual relationship between subcontractor and Bidder's company,
- e) indication of general financial model such as shared savings, PMPM, fee for service, etc.,
- f) percentage of performance hours intended for each subcontract; and
- g) total percentage of subcontractor(s) performance hours.

Confirm that, if awarded a contract with the State, you will agree in the contract to notify the State of changes to this subcontractor list throughout the term of any awarded contract and that the State will have the ability to pre-approve any subcontractor that provides services directly to the State or its members.

Our organization leverages external third-party subcontractors to augment our operations and service offerings, when/where appropriate. We have programs in place to assure that these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements.

Because of the broad spectrum of UnitedHealth Group businesses and subcontractor relationships, we are unable to provide a complete list of proposed subcontractors at this time.

Please refer to “122436 O5 UnitedHealthcare Pharmacy - Pharmacy Subcontractor List” provided with our proposal response.

k. PENDING LITIGATION

The bidder will state whether there is any concluded or pending litigation against the Bidder or Bidder's affiliates, subsidiaries, employees related to a contract engagement; and if such litigation exists, an attached opinion of counsel as to whether the pending litigation will impair the firm's performance in a contract under this RFP.

Because of the nature of our business, we are routinely subject to lawsuits alleging various causes of action. Although the results of pending litigation are always uncertain, we do not believe the results of any such actions, currently threatened or pending, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or the results of our operations. Any material litigation or legal actions are disclosed in our financial statements available on the UnitedHealth Group Incorporated (UnitedHealth Group) website: www.unitedhealthgroup.com. UnitedHealth Group is our parent company.

l. BANKRUPTCY

The Bidder will state whether, in the last ten years, Bidder or any of its affiliates or subcontractors has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors; and if so, an explanation providing relevant details.

To the best of our knowledge, in the last 10 years, we have neither filed (or had filed against us) any voluntary or involuntary bankruptcy or insolvency proceeding, nor have we undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

m. FINANCIAL RATINGS

Indicate the most recent Financial Rating, Financial Rating Modifiers and the Financial Rating Effective Date you have received by the following organizations. Indicate all changes that have occurred in the last 12 months for each of these ratings.

- a) A.M. Best
- b) Standard & Poor's
- c) Moody's
- d) Fitch

The Bidder should indicate if its rating has changed within the past 12 months for any of the rating agencies.

We have provided UnitedHealth Group Incorporated's current senior unsecured debt ratings from Standard & Poor's, Moody's, Fitch and A.M. Best Company rating services in the chart below.

Standard and Poor's Rating: A+

Moody's Rating: A2

Fitch Rating: A

A.M. Best: a

There have been no changes within the last 12 months.

n. OTHER MAJOR CHANGES

The Bidder should indicate any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.

We invest in technological enhancements or new processes using a risk-based approach in order to align with regulations and customer expectations.

We regularly upgrade and enhance our systems. In addition to monthly enhancements, we implement comprehensive upgrades to our systems each quarter. These planned enhancements do not represent a material reconfiguration or replacement of the existing

platform or processes.

We continually modify our schedule based on business requirements/needs. Any change that may impact members is communicated through appropriate customer contacts.

Future Enhancements

We regularly update our claim system, scheduling major modifications on a quarterly basis, as well as minor modifications on a monthly basis, as needed. Since the claim system's inception in 1982, we have implemented more than 2,500 enhancements, making both major and minor changes to improve our claim processing capabilities. We aim to create new opportunities for customers to maximize the value of our health care services and health improvement programs.

Our initiatives connect all components of the health and financial delivery system to provide more personalized service and support to our customers. Further, our goal is to improve health and financial behavior by encouraging consumers to play a more educated role in their health care decisions.

Ongoing Initiatives

We continue to monitor our recent initiatives to identify potential improvement opportunities. We encourage feedback from our staff to gain a better understanding of the practical effects of these improvements. A variety of enhancements have been added in the past three years, and we continue to modify and improve those capabilities. The following are among our recent claim system advancements:

The Quality Assurance (QA) Tool

The QA tool is used by installation staff and the QA team to increase quality and efficiency when building our online claims processing system and conducting quality reviews. The QA tool also enables the installation analyst to locate a standard plan design from the plan library and model or copy that plan with the changes required by the customer. The QA tool locates the plan, makes the appropriate changes, attaches any special processing instructions and installs it into our online claims system with minimal keying by the analyst. This helps increase the efficiency and accuracy of our online claims system coding and claim payment.

Improved Manual Claim Processing

Transaction specialists use an intuitive, easy-to-navigate desktop that features pop-up windows, drop-down menus and real-time claim processing tips. This desktop also ensures fewer manual processing steps to further increase speed and accuracy. Our improved transaction desktop provides seamless access to external data resources, as well as reduced research time due to enhanced claim search features and selection capabilities. Through enhanced inventory management reports, managers are able to better assign claim inventories and optimize resources. Our improved transaction desktop reduces the number of claims requiring manual intervention. Currently, 91.7% of claims are automatically adjudicated.

Real-time Adjudication

Our real-time adjudication (RTA) enables physicians and other health care professionals to create claims and submit them in real time through our online claim entry feature. Further, as this process occurs on-site as the member is receiving care, members receive a printed detail of the claim, their benefits and their financial responsibility.

Claims that are validated and automatically adjudicated by this process result in a

“successful” message to the physician or health care professional within seconds. The message includes information about the allowed payment and member responsibility. Any claims that are not adjudicated in real time result in an acknowledgement and a claim identification number for the physician’s or health care professional’s reference.

Consumer Activation

We encourage consumers to take a more active part in their own health care decision making. To support this responsible behavior, we develop the systems and tools that help make those health decisions easier. The following enhancements promote the continued education and awareness of our valued members:

Enhancements to myuhc.com

Our member Internet portal, myuhc.com, continues to be the member’s primary source for simple, convenient benefit access. Recent initiatives further simplify and personalize the member’s experience by providing immediate access to an even greater array of actions and information.

Once members log in to myuhc.com, they have instant access to the following key elements of their benefits:

- Claim and account information, including recent transactions and current balances
- Pharmacy benefits information, such as the status of a recent mail service and links to other pharmacy resources
- At-a-glance plan and benefit summary basics, including deductible and out-of-pocket maximums
- Health News link for information that may be of interest to consumers
- Search tool for finding physicians and other health care professionals, including one-click access to recent searches
- Medical Library for health-related articles, including suggested articles and access to recently viewed articles with one click

In addition, our members can connect to a nurse for live, one-to-one, on-line nurse chats.

2. TECHNICAL RESPONSE

The Technical Response section of the solicitation response should consist of the following subsections:

- a) Understanding of the project requirements;
- b) Proposed development approach;
- c) Technical requirements;
- d) Completed Attachment C – Confirmations & Questionnaire;
- e) Completed Formulary Disruption Analysis as requested in Questionnaire Tab D.3;
- f) Completed Network Disruption Analysis as requested in Questionnaire Tab F.14;
- g) Completed Attachment D – Performance Guarantees;
- h) Detailed project work plan; and
- i) Deliverables and due dates.

Noted.

CONTRACTUAL AGREEMENT FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder is not owned by the Chinese Communist Party. **Confirmed.**

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603, DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Vendors. This information is for statistical purposes only and will not be considered for contract award purposes.

X **NEBRASKA VENDOR AFFIDAVIT:** Bidder hereby attests that bidder is a Nebraska Vendor. "Nebraska Vendor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation. All vendors who are not a Nebraska Vendor are considered Foreign Vendors under Neb. Rev Stat § 73-603 (c).

____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract. **Not applicable.**

____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. § 71-8611 and wish to have preference considered in the award of this contract. **Not applicable.**

THIS FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN

COMPANY:	United HealthCare Services, Inc.
ADDRESS:	9700 Health Care Lane, Minnetonka, Minnesota 55343
PHONE:	(952) 936-1300
EMAIL:	rob_broomfield@uhc.com
BIDDER NAME & TITLE:	Robert Broomfield, Health Plan CEO
SIGNATURE:	
DATE:	July 17, 2025

VENDOR COMMUNICATION WITH THE STATE CONTACT INFORMATION (IF DIFFERENT FROM ABOVE)

NAME:	
TITLE:	

PHONE:	
EMAIL:	

Texas Department of Insurance

Certificate of Authority

Licensed as Third Party Administrator
License no. 2988674

Licensed since: 08-19-1998

Department Certification issued to:

UNITED HEALTHCARE SERVICES, INC.
Organized under the laws of Minnesota

This entity has complied with the laws of the state of Texas applicable to the licensing of Third Party Administrators and is hereby authorized in accordance with **TEX. INS. CODE, Chapter 4151** to transact the business of:

ADMINISTRATOR

This certificate of authority is in full force and effect until it is revoked, canceled, or suspended according to law.

Given under my hand and official seal of office
in the city of Austin,

April 20, 2023

CASSIE BROWN
COMMISSIONER OF INSURANCE

BY


John Carter, Director

Company Licensing and Registration
Financial Regulation Division
Commissioner's order no. 3632





CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
05-02-2025

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

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

PRODUCER MARSH USA LLC. 99 HIGH STREET BOSTON, MA 02110 Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307 CN101631729-MAIN-CRIME-25-26	CONTACT NAME: Enterprise Risk Financing & Insurance PHONE (A/C, No, Ext): E-MAIL ADDRESS: eis@uhg.com	FAX (A/C, No): 888-299-6422
INSURED UNITEDHEALTH GROUP INCORPORATED 1 HEALTH DRIVE EDEN PRAIRIE, MN 55344	INSURER(S) AFFORDING COVERAGE INSURER A : Beazley Insurance Company, Inc. INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :	
	NAIC # 37540	

COVERAGES

CERTIFICATE NUMBER:

CHI-010929834-02

REVISION NUMBER: 0

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB ☐ OCCUR EXCESS LIAB ☐ CLAIMS-MADE DED ☐ RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ Y / N ☒ N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE ☐ OTH-ER ☐ E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	CRIME INCLUDING 3RD PARTY COVERAGE			V23E7D250801	05-01-2025	05-01-2026	LIMIT PER OCCURRENCE 5,000,000

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

CERTIFICATE HOLDER

CANCELLATION

UNITEDHEALTH GROUP INCORPORATED 1 HEALTH DRIVE EDEN PRAIRIE, MN 55344	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE <i>Marsh USA LLC</i>

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V. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Solicitation.

A. PROJECT OVERVIEW

State of Nebraska ("State") employs approximately 17,500 individuals and 13,600 are enrolled in health plans. Enrolled members include active employees, pre-65 retirees, COBRA participants, and their dependents. Members are primarily located throughout the State of Nebraska. The State allows both Union and non-Union employees to be enrolled in one of the three (3) State health plans. The State currently has the following self-insured medical and prescription drug plans:

- Regular Plan
- Consumer Focused Health Plan (with Health Savings Account Eligibility)
- WellNebraska (with or without incentive)

The State's objective is to secure competitive and transparent pricing for pharmacy benefit management (PBM) services while maintaining and enhancing the quality of the pharmacy benefit plan and maximizing employee satisfaction. The State also seeks clinical and utilization management programs that will effectively reduce costs and waste while ensuring the highest standard of patient care.

The State currently has Contract 89546 O4 for Administrative and Support Services for the State of Nebraska Employee Health Care Benefits and Pharmacy Benefit Plans. This includes the administration of the Health Savings Account program and a Specialty Pharmacy Program.

Information about the current health plans offered to plan members is available at:

<http://das.nebraska.gov/benefits.html>

Health Plans (Plan Options: Regular, Consumer Focused, and WellNebraska) can be found at:

<https://das.nebraska.gov/personnel/wellness/health-and-perscription-benefits.html>

The State's Plan Year runs from July 1 to June 30. Note that it is the expectation of the State that work on this contract will begin immediately upon award, with a focus on implementation and Open Enrollment (OE) support (i.e., development of OE documents).

PBM Fees will not be paid until the benefit plan year begins on July 1, 2026.

Noted.

B. ENROLLMENT

The following is a table representing State active employees, pre-65 retirees, COBRA participants, and their dependents participation in each health plan by tier, as of February 2025. This may not be an exact match to the Census Data:

Plan/Tier	Regular PPO	Wellness PPO with incentive	Consumer Focused Health Plan (HDHP)	Wellness without Incentive	Total
Employee Only	1,079	4,289	1,137	306	6,811
Employee/Spouse	345	1,400	193	74	2,012
Employee/Child(ren)	227	1,432	193	86	1,938
Family	293	2,136	286	171	2,886
Total	1,944	9,257	1,809	637	13,647

Noted.

C.PROJECT OBJECTIVES

The State of Nebraska is looking to provide high quality, cost-effective benefits to its active employees, pre-65 retirees, COBRA participants, and their dependents. The State is soliciting offers for the administration of its self- insured prescription drug plan. Bidders are required to offer comprehensive PBM services with a full range of customer (client and member) services including, but not limited to:

1. Claim Adjudication
2. Member Enrollment and Eligibility Maintenance
3. ID Card Production and Distribution
4. Formulary Management and Rebate Pass-Through
5. Clinical and Utilization Management
6. Retail Pharmacy Network Management
7. Specialty and Mail Order Pharmacy
8. Patient and Provider Education
9. Systematic Prospective, Concurrent and Retroactive Drug Utilization Review
10. Auditing Rights
11. Account Management Services (including standard/custom reporting and online systems)
12. Member Services (including call center, website portal and mobile app)
13. Claims data sharing with State, healthcare and data analytic vendors

Please note that the State is concurrently conducting a procurement for medical administration services. This RFP is only for PBM services, and any information provided by respondents which pertains to the medical administration RFP or any other service (unless explicitly requested within the RFP), will not be considered in evaluation of this RFP. This includes attempts by Bidders to provide PBM fees that are contingent upon the additional award of business in connection with the medical administration RFP.

Noted.



D. SUBROGATION REQUIREMENT

Contractor shall enforce the State's right to seek recovery based on subrogation or other theories from third parties, or other insurance carriers, who have caused injury or illness to a covered person or damages to the plan, except when said third party is the State of Nebraska. Contractor shall provide subrogation recovery service at no additional charge to the State. Contractor may engage a subcontractor to perform specialized services for recovery of funds or discovery of overpayment or fraud. If any subrogation services are subcontracted by contractor, approval of subcontractors and contract terms must be obtained from the State prior to contractor entering into an agreement with any such subcontractor(s). Such subcontractors may be reimbursed based on a reasonable basis other than percent of recovery, but cost of such subcontractors shall be the responsibility of Contractor and shall not be deducted from the subrogated amount. The Contractor shall obtain the approval of the State for any subrogation claim that is less than 100% of the State's loss and shall obtain the State's approval of all settlements. In the event that the State is a party to litigation regarding any such claims, settlement or release of such claims must be approved by the State. This authority regarding recoveries from third parties or their carriers includes participation in consolidated or class action lawsuits alleging such injuries, if authorized by the State. Any recovery from consolidated or class action suits will be apportioned among all insured and self-insured plans or pools in like manner. The proration may be based on number of covered persons, number of injured persons, claims volume, or any other basis determined by contractor and approved by the State. Recoveries made in the same plan year as the original claim payments are made, will be applied to the State's claims liability by immediate credit to the State. Recoveries made in subsequent years will be credited in total to the State's claim liability at the time recovery is made. The State agrees to cooperate with all such recovery efforts.

Noted.

E. PRESCRIPTION PLAN DESIGN

At a minimum, the Contractor must duplicate the plan designs and level of coverage presently offered to the State's covered member population.

Noted.

F. PLAN REQUIREMENTS

The Contractor must adhere to the following Plan Requirements. These requirements will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State.

1. Provide services to all members (active employees, pre-65 retirees, COBRA participants, and their dependents) enrolled on the program effective date

Noted.

2. Agree that members who are not actively at work due to disablement on program effect date will be covered.



Agreed.

3. Agree that the State owns its data (its financial and operational data, and its member data), may use it for any business purposes it deems necessary, and that such data will be considered proprietary and will not be shared or utilized by Contractor for any purpose other than the provision of services under the agreement, except at the request of the State's Director of Administrative Services, and with full knowledge and express written consent.

Agreed,

4. Acknowledges the State will neither recognize the appointment of any agent, general agent or broker nor authorize any payment or remuneration of any kind by the Contractor to a party not approved in writing by the State.

Noted.

5. Advise and assist the State in the preparation of forms and other documentation necessary to fulfill reporting and disclosure requirements.

We will provide administrative services consistent with the State's plan design(s) in accordance with the terms of our administrative services agreement (ASA) with you, and in accordance with all relevant laws and regulations. However, as the plan sponsor of your self-funded benefit plan, you retain ultimate responsibility for the legal sufficiency of your plan design and summary plan description (SPD) content, in accordance with applicable laws.

6. Agrees it will not render or administer services (including wellness) offshore, and all work performed will be in the contiguous United States.

Confirmed.

7. Comply with and adhere to relevant federal and state laws and regulations.

Noted.

8. Monitor Federal and State legislation affecting the plan and report to the State on those issues in a timely fashion and prior to the effective date of any mandated plan changes.

Our legal services staff maintains awareness of pertinent legal issues, decisions and rulings, and communicates updates to the relevant areas of our company, including a dedicated regulatory team. New laws affecting our business are disseminated to the relevant business areas of our company.

9. Assume responsibility for any and all costs associated with any investigation necessary to ensure that claims are adjudicated properly.

Agreed.



10. Follow the specified eligibility rules established by the State.

Confirmed. Eligibility determinations are based on the eligibility information provided to us by the State. We assume you own your eligibility rules and verify eligibility under the plan.

11. Agree to all requirements as outlined in Attachment C – Confirmations & Questionnaire, Confirmations tab.

Not confirmed. We have provided additional information where we cannot agree.

12. Assign a dedicated Account Management Team (AMT) who shall be accountable and responsible to the State for proactive management of all aspects of the Contractor's performance to the State and its members. The Contractor shall not change assignment of the Account Executive on the AMT, without written notice provided to the State with a minimum of fourteen (14) business days prior to such change. The State reserves the right to request assignment of a new Account Executive, and the Contractor shall make such change within 30 calendar days of receipt of written notice from the State. A member of the AMT must respond to any outreach from the State of Nebraska within one (1) business day.

Noted.

13. Provide a mutually agreed upon annual score card so the State can assess Contractor's performance.

Noted.

14. Provide claim line detail for ALL claims as described in this RFP.

Noted.

15. Provide robust, accurate, timely, and comprehensive data and reporting to the State. The State and its healthcare consultants must have the ability to access a reporting portal to download all reports. This provision includes HEDIS reports or State specific utilization data for State members, upon request.

Online reports are available monthly through our employer portal, Employer eServices, and the data to support reports are updated on the 10th business day following the reporting month. You can initiate reporting requests at any time and review the reports online after allowing a momentary processing time.

16. Provide data feeds (ex. eligibility file) to the State's vendor partners, as requested. The cost for providing data feeds must be included in the Contractor's administrative fees. Contractor agrees to waive any charges to the State or the State's vendors such as a set-up fee, a programming fee or a monthly fee, for establishing a connection with a third party vendor for real-time, bidirectional data integration, including non-standard data integration formats.

Current data feeds will remain in place; however, UnitedHealthcare reserves the right to pass along the cost of future requests. Pricing can be provided upon request.

17. The Contractor must perform and present to the State, on a quarterly or as requested basis, the State's current plans and service performance, recent issues/challenges encountered, potential savings opportunities, and topics of concern and suggestions for resolution, at no additional cost to the State.

Noted.

18. Attend an annual performance or "stewardship" meeting within 180 days after contract year-end at which time the Contractor will, as directed by the State, summarize activities and performance for the year ended.

Noted.

19. Participate in an Annual Vendor Summit to discuss strategic opportunities for the State's overall health management program.

Noted.

20. Provide final Summary Plan Documents (SPD), written and electronic, including SPD language for any clinical programs to be implemented, to the State prior to the initial Open Enrollment period and subsequent open enrollments. SPDs are subject to the final approval of the State.

Noted.

21. Agree to provide an opportunity for the State to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and/or to providers.

Confirmed.

22. Complete implementation prior to the State's Annual Open Enrollment period each May.

Noted.

23. Agree that no external communications material that mentions the State's benefit plans may be circulated without written approval from the State.

Confirmed.

24. Attend and participate in the annual Human Resource Information Group (HRIG) in April of each year. The Contractor is also required to participate in the informational meetings across the State directly following the HRIG. If requested by other State agencies, the Contractor may participate in agency specific health fair(s).

Noted.

25. Offer program to prevent and detect internal and external fraud and fraudulent practices.

Noted.

26. Administer run-out claims for 12-months following termination of the contract. The cost of run-out administration must be included in bidder's proposed administration fees.

Noted.

27. Provide complete banking arrangements for claims processing, including the printing and issuing of checks and/or electronic funds transfer.

Noted.

28. No covered State members shall lose or gain coverage as a result of vendor change. Any and all transition- of-care-related issues must be expressly waived for the initial enrollment for covered eligibles and their dependents that have already satisfied the limitations under the existing plan, unless otherwise specified in the eligibility rules established by the State.

Noted.

29. Complete formulary disruption and retail network disruption analyses as detailed in the Questionnaire.

Noted.

30. **Attachments:** Complete all RFP attachments:
 - a. Attachment A – Intent to Propose
 - b. Attachment B – Business Associate Agreement (BAA)
 - c. Attachment C – Confirmations & Questionnaire
 - i. Completed Formulary Disruption Analysis as requested in Questionnaire Tab D.3
 - ii. Completed Network Disruption Analysis as requested in Questionnaire Tab F.14
 - d. Attachment D – Performance Guarantees
 - e. Cost Sheet

Noted.

G. BUSINESS REQUIREMENTS

1. Contractor must be currently providing self-funded PBM administration services to at least one public sector group health plan with a minimum of 15,000 lives.



Noted.

2. Contractor must have a minimum of five (5) years of self-funded PBM administration group experience.

Noted.

3. Contractor must be licensed to offer employer-sponsored, network-based self-funded PBM plan solutions in all 50 states and U.S. territories where State members currently reside.

Confirmed. Please refer to “122436 O5 UnitedHealthcare - TX - UHS TPA Perpetual” provided with our proposal response.

4. Contractor must not have any bankruptcy filings within the last 5 years; and Offeror's senior officers, board members, or directors must not have any felony convictions.

To the best of our knowledge, in the last five years, we have neither filed (or had filed against us) any voluntary or involuntary bankruptcy or insolvency proceeding, nor have we undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

To the best of our knowledge, none of our employees or subcontractors are felons who have been convicted of a crime related to the job they are hired to perform.

We perform background checks on potential employees prior to hiring them and, with discretion, throughout the course of employment.

In addition, we have an office of ethics and integrity that requires employees and contractors to report all suspected illegal or unethical conduct, including violations of law, contractual obligations and company policies or concerns about accounting, internal controls, auditing matters or suspected fraud and abuse.

If misconduct occurs, we investigate the matter, take disciplinary action, if necessary, and implement corrective measures to prevent future violations. We also have fidelity/crime insurance coverage, which protects our organization from losses arising from employee dishonesty, forgery, theft, robbery, burglary and fraud.

Furthermore, our procurement contract negotiators routinely include an exhibit attached to a master services agreement that addresses background checks for vendor personnel who require independent access to our information systems and/or physical facilities.

H. DELIVERABLES

Provide the following third-party administration services for the State's Medical plan coverage as listed in this RFP:

1. Claims Adjudication



2. Member Enrollment and Eligibility Maintenance
3. ID Card Production and Distribution
4. Formulary Management and Rebate Pass-Through
5. Clinical and Utilization Management
6. Retail Pharmacy Network Management
7. Specialty and Mail Order Pharmacy
8. Patient and Provider Education
9. Systematic Prospective, Concurrent and Retroactive Drug Utilization Review
10. Auditing Rights
11. Account Management Services (including standard/custom reporting and online systems)
12. Member Services (including call center, website portal and mobile app)
13. Claims data sharing with the State, healthcare and data analytic vendors

Noted.

PHARMACY PROPOSAL DEVELOPMENT OVERVIEW

We'll partner with you to determine what best matches your needs from the broad arrange of solutions State of Nebraska already has. Whatever your goal, we have a robust pharmacy profile ensuring that we are caring for your teammates.

Highlighted below are some programs that have the greatest impact. Whatever your goal, we have a robust pharmacy profile that can align to The State of Nebraska's needs, while ensuring that we are caring for your teammates.

The right strategies helping balance cost and positive health outcomes



ADDRESSING TREND DRIVERS

We have the expertise and strategies to address the biggest trend drivers in the market right now – GLP-1 management and biosimilar management.

- GLP-1 management:
- Biosimilar management: Biosimilars are compared with respective innovators based on cost and other factors; “preferred” designation and PDL placement drive utilization of higher value therapies

THE RIGHT CONNECTIONS BETWEEN PHARMACY AND MEDICAL

- Pipeline management: With insights from our P&T committee, we model the financial impact and potential member impact of drug coverage across both pharmacy and medical benefits. These findings inform our decisions about coverage for high-value drugs

- Network solutions: Like our medical networks, Optum Rx® maintains several network options to serve our customers and members, including retail and specialty pharmacy locations.
- PreCheck MyScript: Integrated within the prescriber's electronic medical records system to allow for real-time coverage and cost information to be seen at the point of prescribing
- Utilization Management: Requirement that providers notify us and complete a clinical review to determine medication coverage
- Dx2Rx: Satisfies prior authorization requirements by conducting real-time medical claims checks to automatically find a member's diagnosis in claims history
- Point of Sale Quick Check: Validates existing member data to bypass prior authorizations when appropriate
- APAS: A suite of audit services offered in conjunction with our standard services to detect, correct, and prevent fraud, waste, abuse (FWA) and error in the pharmacy n
- Specialty Medical guidance program: – Single platform that analyzes non-oncology therapies covered under the medical benefit and gives providers real-time authorization decisions based on clinical evidence
- Specialty Trend management: Integrates pharmacy and medical benefits to ensure the right drug is delivered at the right cost in the right setting which can reduce total cost of care while improving outcomes

THE RIGHT COST STRATEGIES

- PDL Management : Prescription Drug Lists (PDLs) options are lists of pharmacy-benefit covered drugs with exclusion and tiering configurations. They are coupled with benefit designs and strategic exclusions, allowing variation in price points to meet customer preferences.
- Vital Medication Program: Select insulins and other important medications at \$0 cost-share; standard for FI and optional for ASO
- Preventive Drug List: – Plan design where specific lists of prescription drugs are designated as preventive and thereby offered at \$0 or reduced cost-share and provided as first-dollar coverage
- Copay Card Solutions: Drug manufacturers offer copay cards (coupons) to lower member out-of-pocket costs. Left unchecked, copay card funds count toward member deductibles and out-of-pocket maximums. Our solutions give members access to these money-saving copay cards, while also ensuring that accumulators track only their true out-of-pocket costs.
- POS discounts: – Program that shares manufacturer rebates directly with members at the prescription counter via real-time price adjustments
- Value Based contracts: Fixed value contracts enable prescription drug list (PDL) management that drives toward lower total cost of care across both medical and pharmacy benefits



- Polypharmacy management: A de-prescribing module where Optum Rx pharmacists reach out to UnitedHealthcare members who are on 5 or more medications; pharmacists work with members and their prescribing physicians to ensure they need to be taking each prescription drug and that there are no dangerous interactions between those medications
- Price Edge: Product that intends to add a “cash informed” pricing layer into Rx claims—functioning as lessor-of logic when the cash price is lower than the member’s insured prescription drug price—to eliminate frequency of member finding lower cost prescription drugs through GoodRx
- Enhanced Savings Program: Automatically triggers the Optum Perks price at point-of-sale for a subset of excluded medications, delivering an improved member experience in those instances
- Easy Payment Plan: A plan that allows members to split the cost of a home delivery prescription into 3 monthly payments
- Proactive Savings Alerts: A push marketing capability that harnesses savings opportunities from our Best Price Engine and shares them with members via email with a link to our Savings Center on myuhc.com.
- Sempre Health: enrolled members receive text reminders, those who refill on time receive copay rewards
- Savings IQ: a digital tool designed to help eligible Optum Specialty Pharmacy patients access financial assistance for their medications. It automatically matches patients with available savings programs, reducing out-of-pocket costs and improving medication adherence.

THE RIGHT EXPERIENCE

- Advocate4Me : Access to a pharmacist whenever a teammate needs
- MyUHC App: Single app for medical and pharmacy
- Referrals for behavioral health, nutrition counseling, physical therapies, cancer support and other resources.
- Cancer Guidance Program: – Single platform that analyzes oncology regimens—including therapies covered under both medical and pharmacy benefits—and gives providers real-time authorization based on National Comprehensive Cancer Network (NCCN) guidelines and other clinical evidence
- Home delivery: With Optum Home Delivery Pharmacy, members taking medications for chronic conditions can get a 90-day supply at a lower cost.
- Free Meter program: Members get a meter—at no additional cost to them—to help monitor their blood sugar levels and manage their diabetes



In conclusion, UnitedHealthcare Pharmacy / OptumRx offers a suite of innovative programs and tools designed to provide exceptional care and financial relief for patients. From Gene Therapy Risk Protection to Savings IQ, Advocate4Me, and the Cancer Guidance Program, each initiative is crafted to ensure seamless access to necessary treatments, while minimizing out-of-pocket expenses. By integrating these solutions into everyday healthcare practices, Optum Rx and UnitedHealthcare are committed to improving patient outcomes and overall well-being and reducing overall medical trend.

Note: Underlined items already in place.



VI. SOLICITATION RESPONSE INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Corporate Overview and Technical Response portions of the solicitation response. The solicitation Cost Sheet template should be completed by bidders and submitted as a separate attachment with their solicitation response. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their solicitation response; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Solicitation responses are due by the date and time shown in the Schedule of Events. Content requirements for the Corporate Overview and Technical Response are presented separately in the following subdivisions:

A. SOLICITATION RESPONSE SUBMISSION

1. CORPORATE OVERVIEW

The Corporate Overview section of the solicitation response should consist of the following subdivisions.

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business (including whether the Bidder is in good standing in the state in which it is formed or incorporated, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized. The Bidder should also provide this information for the branch or local office or other subordinate element that will perform or assist in performing the work on this contract.

The bidder should indicate whether it operates as an individual, partnership, limited liability company, or corporation.

**United HealthCare Services, Inc.
9700 Health Care Lane
Minnetonka, Minnesota 55343**

UnitedHealthcare is a corporation and one of the family of businesses that comprise UnitedHealth Group.

United HealthCare Services, Inc. was incorporated in Minnesota on September 17, 1974.

b. FINANCIAL STATEMENTS



The bidder should provide its organization's last audited financial statement and the most recent unaudited financial statement if the most recent audited financial statement is older than 12 months as well as the latest SSAE 21 report. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that solicitation evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

Confirmed. Please refer to "122436 O5 UnitedHealthcare - Annual Financial Report" provided with our proposal response.

The State can access our latest SSAE 18 (SOC 1, Type II) reports on eServices.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the solicitation response due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

The bidder should state and describe if it recently experienced any workforce realignments and/or recent merger or acquisition activity. Include in this description, any anticipated changes in ownership or business developments, including but not limited to mergers, stock issues, and the acquisition of new venture capital.

There are no pending or anticipated ownership changes. As a public company, our shares trade every day, but the large owners have generally been stable and no one has purchased, or is expected to purchase, a 10% or greater position in the company.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.



2717 N. 118th Street, Suite 300, Omaha, Nebraska 68164.

e. RELATIONSHIP WITH THE STATE

The bidder should describe any dealings with the State over the previous twelve (12) months. If the organization, its predecessor, or any Party named in the bidder's solicitation response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Contract# 744240 Medical/Carve-In Pharmacy 306147 – STD/LTD.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's solicitation response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for solicitation response submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this solicitation. If no such relationship exists, so declare.

There are no disclosed relationships with the State.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past (three) (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past (three) (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's solicitation response accordingly. If no such termination for default has been experienced by the bidder in the past (three) (3) years, so declare.



If at any time during the past (three) (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

To the best of our knowledge, we have not had a customer contract termination due to default, failure to complete or legal action.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this Solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the solicitation response.

The bidder should address the following:

- i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Solicitation. These descriptions should include:
 - a) The time period of the project,
 - b) The scheduled and actual completion dates,
 - c) The bidder's responsibilities,
 - d) Key strengths or competitive advantage that differentiates the Bidder's company from Bidder's competitors,
 - e) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
 - f) Each project description should identify whether the work was performed as the prime Vendor or as a subcontractor. If a bidder performed as the prime Vendor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.
- ii. Bidder and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as subcontractor projects.
- iii. If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

Please refer to "122436 O5 UnitedHealthcare - Summary of Bidders Experience" provided with our proposal response.



i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The State will continue to be supported by a multi-functional account management team (AMT), who is your point of contact for all aspects of administration, claims, underwriting, contracts, eligibility, billing and reporting and will work to meet your service needs. Essential roles include:

- **Jelena Edwards, Strategic Account Executive (SAE) – Customer relationship owner with overall responsibility of your account.**
- **Travis Granger, Implementation Manager (IM) – Manages/oversees the implementation process if plan changes are decided to be made.**

We recognize the State is a unique company with unique employees, and we believe the AMT structure outlined above offers functional expertise and excellence, while maintaining a customer focus.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface, and support functions, and reporting relationships. The primary work assigned to each person should also be identified. For each team member listed, identify whether this staff member will be 100% dedicated/designated to the State account. If the member is not 100% dedicated/designated to the State, please indicate the percentage of time the staff member will designate to the State account as well as the number of other clients with which the staff member has responsibilities. At a minimum, the specific professionals should include:

a. Implementation Coordinator/Manager

Travis Granger, Implementation Manager (IM). Based on average workload, an IM spends between 8% to 20% of their time dedicated to a customer's needs.

b. Account Executive

**Jessica Czajka, OptumRx Regional Account Executive
Jessica has 100 clients and will dedicate 15% to 20% of her time to the State.**

c. Eligibility Coordinator/Manager

Janelle Lundin, Electronic Eligibility Analyst. Janelle works with 24 clients. Once each file comes in and is reviewed, Janelle will dedicate



100% of her time to the files.

d. Pharmacist

Wayne Knisley, Pharmacist

Wayne has about 100 clients and will dedicate 5% to 10% of his time to the State.

e. Member Service Manager

EricaLee Fortner, UnitedHealthcare Service Account Manager, works with 5 clients and will spend 30% of her time dedicated to the State.

f. Government/Legislative Liaison

Wade Hapgood, Government/Legislative Liaison, is assigned to the states of Kansas, Nebraska and Montana. Engagement varies depending on the needs but time dedicated will be 33%.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Confirmed. Please refer to "122436 O5 UnitedHealthcare - Account Management Team Resumes and Bios" provided with our proposal response.

The bidder to note any positions bidder will need to hire if awarded this contract.

The bidder will provide an organization chart, including names and titles, of Account Team and key personnel that will be responsible for the State account.

Confirmed. Please refer to "122436 O5 UnitedHealthcare - State of Nebraska Organizational Chart" provided with our proposal response.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

- a.** name, address, and telephone number of the subcontractor(s),



- b. specific tasks/types of services provided for each subcontractor(s),
- c. number of years Bidder's company has utilized the subcontractor,
- d. contractual relationship between subcontractor and Bidder's company,
- e. indication of general financial model such as shared savings, PMPM, fee for service, etc.,
- f. percentage of performance hours intended for each subcontract; and
- g. total percentage of subcontractor(s) performance hours.

Confirm that, if awarded a contract with the State, you will agree in the contract to notify the State of changes to this subcontractor list throughout the term of any awarded contract and that the State will have the ability to pre-approve any subcontractor that provides services directly to the State or its members.

Our organization leverages external third-party subcontractors to augment our operations and service offerings, when/where appropriate. We have programs in place to assure that these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements.

Because of the broad spectrum of UnitedHealth Group businesses and subcontractor relationships, we are unable to provide a complete list of proposed subcontractors at this time.

Please refer to "122436 O5 UnitedHealthcare - Pharmacy Subcontractor List" provided with our proposal response.

k. PENDING LITIGATION

The bidder will state whether there is any concluded or pending litigation against the Bidder or Bidder's affiliates, subsidiaries, employees related to a contract engagement; and if such litigation exists, an attached opinion of counsel as to whether the pending litigation will impair the firm's performance in a contract under this RFP.

Because of the nature of our business, we are routinely subject to lawsuits alleging various causes of action. Although the results of pending litigation are always uncertain, we do not believe the results of any such actions, currently threatened or pending, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or the results of our operations. Any material litigation or legal actions are disclosed in our financial statements available on the UnitedHealth Group Incorporated (UnitedHealth Group) website: www.unitedhealthgroup.com. UnitedHealth Group is our parent company.

I. BANKRUPTCY



The Bidder will state whether, in the last ten years, Bidder or any of its affiliates or subcontractors has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors; and if so, an explanation providing relevant details.

To the best of our knowledge, in the last 10 years, we have neither filed (or had filed against us) any voluntary or involuntary bankruptcy or insolvency proceeding, nor have we undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

m. FINANCIAL RATINGS

Indicate the most recent Financial Rating, Financial Rating Modifiers and the Financial Rating Effective Date you have received by the following organizations. Indicate all changes that have occurred in the last 12 months for each of these ratings.

- a. A.M. Best
- b. Standard & Poor's
- c. Moody's
- d. Fitch

The Bidder should indicate if its rating has changed within the past 12 months for any of the rating agencies.

We have provided UnitedHealth Group Incorporated's current senior unsecured debt ratings from Standard & Poor's, Moody's, Fitch and A.M. Best Company rating services in the chart below.

Standard and Poor's Rating: A+

Moody's Rating: A2

Fitch Rating: A

A.M. Best: a

There have been no changes within the last 12 months.

n. OTHER MAJOR CHANGES

The Bidder should indicate any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.

We invest in technological enhancements or new processes using a risk-based approach in order to align with regulations and customer expectations.

We regularly upgrade and enhance our systems. In addition to monthly enhancements, we implement comprehensive upgrades to our systems each quarter. These planned



enhancements do not represent a material reconfiguration or replacement of the existing platform or processes.

We continually modify our schedule based on business requirements/needs. Any change that may impact members is communicated through appropriate customer contacts.

Future Enhancements

We regularly update our claim system, scheduling major modifications on a quarterly basis, as well as minor modifications on a monthly basis, as needed. Since the claim system's inception in 1982, we have implemented more than 2,500 enhancements, making both major and minor changes to improve our claim processing capabilities. We aim to create new opportunities for customers to maximize the value of our health care services and health improvement programs.

Our initiatives connect all components of the health and financial delivery system to provide more personalized service and support to our customers. Further, our goal is to improve health and financial behavior by encouraging consumers to play a more educated role in their health care decisions.

Ongoing Initiatives

We continue to monitor our recent initiatives to identify potential improvement opportunities. We encourage feedback from our staff to gain a better understanding of the practical effects of these improvements. A variety of enhancements have been added in the past three years, and we continue to modify and improve those capabilities. The following are among our recent claim system advancements:

The Quality Assurance (QA) Tool

The QA tool is used by installation staff and the QA team to increase quality and efficiency when building our online claims processing system and conducting quality reviews. The QA tool also enables the installation analyst to locate a standard plan design from the plan library and model or copy that plan with the changes required by the customer. The QA tool locates the plan, makes the appropriate changes, attaches any special processing instructions and installs it into our online claims system with minimal keying by the analyst. This helps increase the efficiency and accuracy of our online claims system coding and claim payment.

Improved Manual Claim Processing

Transaction specialists use an intuitive, easy-to-navigate desktop that features pop-up windows, drop-down menus and real-time claim processing tips. This desktop also ensures fewer manual processing steps to further increase speed and accuracy. Our improved transaction desktop provides seamless access to external data resources, as well as reduced research time due to enhanced claim search features and selection capabilities. Through enhanced inventory management reports, managers are able to

better assign claim inventories and optimize resources. Our improved transaction desktop reduces the number of claims requiring manual intervention. Currently, 91.7% of claims are automatically adjudicated.

Real-time Adjudication

Our real-time adjudication (RTA) enables physicians and other health care professionals to create claims and submit them in real time through our online claim entry feature. Further, as this process occurs on-site as the member is receiving care, members receive a printed detail of the claim, their benefits and their financial responsibility.

Claims that are validated and automatically adjudicated by this process result in a “successful” message to the physician or health care professional within seconds. The message includes information about the allowed payment and member responsibility. Any claims that are not adjudicated in real time result in an acknowledgement and a claim identification number for the physician’s or health care professional’s reference.

Consumer Activation

We encourage consumers to take a more active part in their own health care decision making. To support this responsible behavior, we develop the systems and tools that help make those health decisions easier. The following enhancements promote the continued education and awareness of our valued members:

Enhancements to myuhc.com

Our member Internet portal, myuhc.com, continues to be the member’s primary source for simple, convenient benefit access. Recent initiatives further simplify and personalize the member’s experience by providing immediate access to an even greater array of actions and information.

Once members log in to myuhc.com, they have instant access to the following key elements of their benefits:

- Claim and account information, including recent transactions and current balances
- Pharmacy benefits information, such as the status of a recent mail service and links to other pharmacy resources
- At-a-glance plan and benefit summary basics, including deductible and out-of-pocket maximums
- Health News link for information that may be of interest to consumers
- Search tool for finding physicians and other health care professionals, including one-click access to recent searches

- **Medical Library for health-related articles, including suggested articles and access to recently viewed articles with one click**

In addition, our members can connect to a nurse for live, one-to-one, on-line nurse chats.

2. TECHNICAL RESPONSE

The Technical Response section of the solicitation response should consist of the following subsections:

- a.** Understanding of the project requirements;
- b.** Proposed development approach;
- c.** Technical requirements;
- d.** Completed Attachment C – Questionnaire;
- e.** Detailed project work plan; and
- f.** Deliverables and due dates.

Noted.



State of Nebraska - Estimated Timeline for 07-01-2026

Action Items	Owner	Projected Date
Coordinate kick-off call	UHC	7/1/2026
Case Installation / Administrative		
Kick-off call - Finalize administrative options	UHG / Customer / Broker	7/11/2026
Send account structure for approval	UHG	7/18/2026
Review and provide approval of account structure to Implementation Manager	Customer	7/20/2026
Banking/Billing meeting	UHG / Customer / Broker	7/13/2026
Banking meeting	UHG / Customer / Broker	7/14/2026
Banking letter completed and returned to banking analyst	Customer	7/15/2026
Bank account established	UHG	7/30/2026
HSA meeting	UHG / Customer / Broker	7/20/2026
COBRA meeting	UHG / Customer / Broker	7/20/2026
Provide completed NYHCRA docs to Implementation Manager	Customer	7/25/2026
Eligibility (Medical and RX)		
Eligibility meeting	UHG / Customer / Broker	7/21/2026
Open enrollment complete	Customer	
Initial eligibility file submitted	Customer	8/1/2026
Confirm eligibility file loaded	UHG	8/3/2026
Medical Benefits		
Medical benefit Intent meeting	UHG / Customer / Broker	7/16/2026
Benefit intent updates completed	UHG	7/21/2026
Benefit detail reports approved	Customer	7/26/2026
Summary of Benefits and Coverage (SBC) provided and finalized	UHG	7/28/2026
Send ID card PDF to customer for review and approval*	UHG	8/1/2026
Review and provide ID card approval to Implementation Manager*	Customer	7/28/2026
ID cards extracted*	UHG	8/4/2026
ID card post marked*	UHG	8/7/2026
Confirm medical claim and customer service ready	UHG	8/25/2026
Prescription Drug Benefits - UHCRx		
Prescription drug benefit intent meeting	UHG / UHCRX/Customer / Broker	7/31/2026
Prescription drug benefits approved	Customer	7/31/2026
Confirm RX benefit claim and customer service	UHG/UHCRX	8/25/2026
Prior Authorization file from prior carrier received/loaded	UHCRX	9/24/2026
Open Refill Transfer file from prior carrier received/loaded	UHCRX	9/24/2026
Prescription Drug Benefits - External PBM		
Confirm Pharmacy Benefits Manager and contact information	Customer	7/11/2026
Confirm eligibility method and ID card ownership*	Customer	7/11/2026
Confirm accumulator integration	Customer	7/11/2026
Provide final account structure document to PBM contact	Customer	7/20/2026

UHC/UHCRx currently supports State of Nebraska and have successfully implemented requested plan design changes and supported their benefits for 13 years. Depending on the complexity of the requests we can typically accommodate any change and any communications to the teammates impacted by changes with as little as 30 days' notice or 60 days if a member mailing is required.

Please note, this is an illustrative Timeline and the actual implementation timeline will vary from this sample. The actual implementation timeline is customized based on the specific products and services chosen and will be provided at the initial implementation meeting.

DELIVERABLES

Provide the following third-party administration services for the State's Medical plan coverage as listed in this RFP:

1. Claims Adjudication
2. Member Enrollment and Eligibility Maintenance
3. ID Card Production and Distribution
4. Formulary Management and Rebate Pass-Through
5. Clinical and Utilization Management
6. Retail Pharmacy Network Management
7. Specialty and Mail Order Pharmacy
8. Patient and Provider Education
9. Systematic Prospective, Concurrent and Retroactive Drug Utilization Review
10. Auditing Rights
11. Account Management Services (including standard/custom reporting and online systems)
12. Member Services (including call center, website portal and mobile app)
13. Claims data sharing with State, healthcare and data analytics vendors

Noted.

DUE DATES

Schedule of Events		
ACTIVITY		DATE/TIME
1.	Release solicitation	June 9, 2025
2.	Last day to submit "Attachment A - Intent to Propose Form" See Section I.H. for submission instructions.	June 18, 2025
3.	Last day to submit written questions – Round 1 ShareFile link for uploading questions: https://nebraska.sharefile.com/r-rc57d4dcb9ffd4c33b80443517e6a3287	June 22, 2025
4.	State responds to Round 1 of written questions through solicitation "Addendum" to be posted to the Internet at: http://das.nebraska.gov/materiel/bidopps.html	June 26, 2025
5.	Last day to submit written questions – Round 2 ShareFile link for uploading questions: https://nebraska.sharefile.com/r-r9db21bad1e7347349072c5a14110b83e	July 6, 2025
6.	State responds to Round 2 of written questions through solicitation "Addendum" to be posted to the Internet at: http://das.nebraska.gov/materiel/bidopps.html	July 9, 2026

7.	Electronic Solicitation Opening – Online Via Webex IT IS THE BIDDER'S RESPONSIBILITY TO UPLOAD ELECTRONIC FILES BY OPENING DATE AND TIME. EXCEPTIONS WILL NOT BE MADE FOR TECHNOLOGY ISSUES. ShareFile Electronic Solicitation Submission Link: https://nebraska.sharefile.com/r-rff7db5fffc8c4fe59d2e4601cfc003db Join Webex Meeting https://sonvideo.webex.com/sonvideo/j.php?MTID=mf31ddcae5249bd04e07bddd8328f4576 Webinar number: 2497 360 3976 Webinar password: 2XAdm5dXE8N (29236539 when dialing from a phone or video system) Agenda: 122436 O5 Electronic Solicitation Opening Join by video system Dial 24973603976@sonvideo.webex.com You can also dial 173.243.2.68 and enter your webinar number. Join by phone +1-408-418-9388 United States Toll Access code: 2497 360 3976 Global call-in numbers	July 18, 2025 2:00 PM Central Time
8.	Review for conformance to solicitation requirements	July 18 - 24, 2025
9.	Evaluation period	July 24, 2025 - TBD
10.	"Vendor Demonstrations" (if required)	TBD
11.	Post "Notification of Intent to Award" to Internet at: https://das.nebraska.gov/materiel/bidopps.html	October 10, 2025
12.	Contract finalization period	October 10, 2025 - TBD
13.	Contract award	TBD
14.	Benefit plan year begins	July 1, 2026

Noted.

