Changes to UnitedHealthcare benefits for 2023

Medical benefit coverage overview

The following is a high level overview of the Certificate of Coverage (COC) changes for groups renewing July 1, 2023, and after. The benefit information provided represents UnitedHealthcare national standards. State-specific regulations will generally override these benefit standards. Please check actual benefit documents for specific coverage details.

Please note

This comparison only applies to employers who have already implemented Affordable Care Act (ACA)-compliant benefit plans.

continued

New Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
Annual Out-Of-Pocket Limit	ACA 2022 Maximum allowed Out-Of-Pocket Limit: • Individual: $8,700 • Family: $17,400 For High Deductible Health Plans, the limit is $7,050 for an individual and $14,100 for a family.	ACA 2023 Maximum allowed Out-Of-Pocket Limit: • Individual: $9,100 • Family: $18,200 For High Deductible Health Plans, the limit is $7,500 for an individual and $15,000 for a family.
Enteral Nutrition	Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include: • Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease • Severe food allergies • Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract Benefits for prescription or over-the-counter formula and products are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian. For the purpose of this Benefit, "enteral formulas" include: • Amino acid-based elemental formulas • Extensively hydrolyzed protein formulas • Modified nutrient content formulas For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in: • Malnourishment; • Chronic physical disability; • Intellectual disability; or • Loss of life.	Benefits are provided for specialized enteral formulas and low protein modified food products, administered either orally or by tube feeding for certain conditions under the direction of a physician. **UM Letter:** Specialized enteral formulas administered either orally or by tube feeding, are covered for certain conditions under the direction of a physician.

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New Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
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 Rider or under Pharmaceutical Products in this section. Benefits are not available for embryo transfer. Benefits are not available for long-term storage costs (greater than 1 year).	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 Rider or under Pharmaceutical Products in this section. Benefits are not available for elective fertility preservation. Benefits are not available for embryo transfer. Benefits are not available for long-term storage costs (greater than 1 year). **UM Letter:** Elective fertility preservation is not a covered benefit.

continued

New Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
Over the Counter 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, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.	New benefit for FDA approved over the counter hearing aids available for ages 18 and over. Over the counter hearing aids will be included in the traditional hearing aid benefit limits as applicable by state. 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 through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing. Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss. Benefits for over-the-counter hearing aids do not require any of the following: • A medical exam • A fitting by an audiologist • A written prescription 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, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost. **UM Letter:** Benefits are provided for certain over-the-counter hearing aids for covered persons age 18 and older who have mild to moderate hearing loss.
Infertility Services	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: – 1 year, if you are a female under age 35 – 6 months, if you are a female age 35 or older • You are a female under age 44 • You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization	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: – 1 year, if you are a female under age 35 – 6 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 **UM Letter:** If infertility services are covered, eligibility for benefits no longer requires the member be a female under age 44.

continued

New Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
Mental Health Care and Substance-Related and Addictive Disorders Services	Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization 5 business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for out-of-network benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/ Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.	Removal of the out-of-network prior authorization requirement for extended outpatient visits for parity with medical services. Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization 5 business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for out-of-network benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **UM Letter:** The prior authorization requirement for extended outpatient treatment visits, with or without medication management, is removed.

continued

New Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
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 properly qualified behavioral health provider. Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with 2 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 • Provider-based case management services • Crisis intervention We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.	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. Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with 2 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 We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care. **UM Letter:** Provider-based case management services are no longer included under Mental Health Care and Substance-Related and Addictive Disorders Services. **UM Letter:** All mental health care and substance-related and addictive disorders 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. **UM Letter:** Members are encouraged to contact the mental health/substance-related and addictive disorders designee for assistance in locating a provider and coordination of care.
Urinary Catheters	Benefits for indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to: • Urinary drainage bag and insertion tray (kit) • Anchoring device • Irrigation tubing set	Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to: • Urinary drainage bag and insertion tray (kit) • Anchoring device • Irrigation tubing set **UM Letter:** External catheters are covered health care services.

2022 to 2023 COC Changes to Exclusions

Topic	Current Exclusion	Renewing Exclusion
Foot Care	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.	The Foot Care exclusion has been modified to include metabolic conditions as part of Federal NBPP anti-age discrimination guidance. Foot Care 1. Routine foot care. Examples include: – Cutting or removal of corns and calluses. – Nail trimming, nail cutting, or nail debridement. – Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease. **UM Letter:** The routine foot care exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
Gender Dysphoria	Partial language represented. G. Gender Dysphoria 1. Cosmetic Procedures, including the following: – Abdominoplasty – Blepharoplasty – Breast enlargement, including augmentation mammoplasty and breast implants – Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple) – Voice modification surgery – Voice lessons and voice therapy	The following exclusions are removed and will be covered for gender dysphoria based upon medical policy: • Breast enlargement, including augmentation mammoplasty and breast implants • Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple) • Voice modification surgery • Voice lessons and voice therapy G. Gender Dysphoria 1. Cosmetic Procedures, including the following: – Abdominoplasty – Blepharoplasty **UM Letter:** The following exclusions are removed under gender dysphoria: breast enlargement, including augmentation mammoplasty and breast implants; thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave; voice modification surgery; voice lessons and voice therapy.

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2022 to 2023 COC Changes to Exclusions

Topic	Current Exclusion	Renewing Exclusion
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. 3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorders and paraphilic 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. 3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorders and paraphilic disorders. **UM Letter:** Adding pyromania and kleptomania to the list of services not covered under the plan unless they are tied to a conduct or impulse control disorder diagnosis.
Nutrition	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 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.	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. **UM Letter:** Individual and group nutritional counseling exclusion does not apply to behavioral/mental health-related nutritional education services that are provided as part of treatment.
Nutrition	Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 1: Covered Health Care Services.	Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under Enteral Nutrition in Section 1: Covered Health Care Services. **UM Letter:** Specialized enteral formulas administered either orally or by tube feeding are covered for certain conditions under the direction of a physician.

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2022 to 2023 COC Changes to Exclusions

Topic	Current Exclusion	Renewing Exclusion
Procedures and Treatments	Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer or Congenital Anomaly.	Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer or Congenital Anomaly. **UM Letter:** Not required, this is a clarification.
Procedures and Treatments	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.	Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment. **UM Letter:** Reconstructive jaw surgery is covered when there is a facial skeletal abnormality and associated functional medical impairment.
Travel	Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. 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.	Addition of other network provider to support covered services when there is gap coverage and the member needs to travel to see a network provider for those services at the discretion of UnitedHealthcare. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back as determined by us. 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. **UM Letter:** Some travel expenses related to covered health care services received from a network provider may be paid back as determined by us.

Changes to Defined Terms

Topic	Current Definition	Renewing Definition
Experimental or Investigational Services	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 we 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.	The definition is clarified to include off-label drug policy and government defined programs. 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 we make a determination regarding coverage in a particular case, are determined to be any of the following: 1. 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 in any of the following: – AHFS Drug Information (AHFS DI) under therapeutic uses section; – Elsevier Gold Standard's Clinical Pharmacology under the indications section; – DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or – National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A or 2B. 2. 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.) 3. 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. 4. Only obtainable, with regard to outcomes for the given indication, within research settings. **UM Letter:** Under the definition of "Experimental or Investigational Service(s)", the following sources were removed as criteria to identify appropriate use: the American Hospital Formulary Service; the United States Pharmacopoeia Dispensing Information. And the following sources were added: AHFS Drug Information (AHFS DI) under therapeutic uses section; Elsevier Gold Standard's Clinical Pharmacology under the indications section; DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A or 2B. Experimental or investigational service(s) are only obtainable, with regard to outcomes for the given indication, within research settings.

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Changes to Defined Terms

Topic	Current Definition	Renewing Definition
Remote Physiologic Monitoring	N/A	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. **UM Letter:** Benefits include "remote physiologic monitoring", which is a defined term.
Residential Treatment	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: • 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. • Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation. Provides at least the following basic services; in a 24-hour per day, structured setting: • 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.	The definition is clarified for written treatment plan provisions. 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: • Provides a program of treatment, under the active participation and direction of a Physician. • 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. **UM Letter:** The requirement to maintain a written, specific and detailed treatment program requiring your full-time residence and participation in the residential treatment definition was replaced with the requirement to offer organized treatment services that feature a planned and structured regimen of care in a 24-hour setting.

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Changes to Defined Terms

Topic	Current Definition	Renewing Definition
Unproven Services	Unproven Service(s) – services, including medications, that are determined not to be effective for treatment of the medical condition and/or 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.	Unproven Service(s) – 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. **UM Letter:** Unproven services include services that are not determined to be effective for the treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

Changes to General Provisions

Topic	Current Benefit	Renewing Benefit
Group Policy– Retro term date	5.1 When Does the Policy End? This Policy and all Benefits for Covered Health Care Services will automatically end on the earliest of the dates shown below: On the last day of the grace period if the Policy Charge remains unpaid. The Group remains responsible for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.	A process change being applied for states identified to term the contract coverage to the last paid date for non-payment. The policy end date will vary by state requirement and if uniform modification applies. 5.1 When Does the Policy End? This Policy and all Benefits for Covered Health Care Services will automatically end on the earliest of the dates shown below: At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date. **UM Letter:** The Policy ends at our option, retroactive to the last paid date of coverage if the grace period expires and the Policy charge remains unpaid on the due date.
Group Policy - When is the Policy Charge Adjusted and When is the Policy Charge Paid	3.3 When Is the Policy Charge Adjusted? The Group must notify us in writing, or within [30–90] days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing, each month of any change in the Coverage Classification for any Subscriber. 3.4 How Is the Policy Charge Paid? The Policy Charge is payable to us [in advance] by the Group as described under "Payment of the Policy Charge" in Exhibit 1. [The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force.]	A process change to require customers to pay for membership as reflected by the customer's eligibility submissions at the time of bill generation without allowing manual changes to the amount of the bill based on eligibility adjustments. 3.3 When Is the Policy Charge Adjusted? The Group must notify us in writing, through our electronic systems, or by other methods as determined by us within [30–90] days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing, through our electronic systems, or by other methods as determined by us each month of any change in the Coverage Classification for any Subscriber. 3.4 How Is the Policy Charge Paid? The Policy Charge is payable to us [in advance] by the Group as described under "Payment of the Policy Charge" in Exhibit 1. The Group agrees to remit to us the Policy Charge due which is based on our enrollment records as provided by the Group at the time the invoice for the Policy Charge is issued. [The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force.] If the Policy Charge remains unpaid, the Policy will end as described below under 5.1 When Does the Policy End? **UM Letter:** The policy charge is based on the enrollment records as provided by you at the time the invoice for the policy charge is issued. You must notify us of enrollments, terminations or other changes in writing or through our electronic system or by other methods as determined by us.

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Changes to General Provisions

Topic	Current Benefit	Renewing Benefit
Allowed Amounts and Gap Language	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 us. Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment, or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.	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. • Unless specifically provided otherwise, when Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us, unless a different amount is required by applicable law, a rate determined based upon the median amount negotiated with Network providers for the same or similar service. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay. **UM Letter:** When covered health care services are received from an out-of-network provider as arranged by us, including when there is no network provider who is reasonably accessible or available to provide covered health care services, allowed amounts are an amount negotiated by us or an amount permitted by law.
Medicare Estimation	When calculating the Coverage Plan's Benefit in these situations, we use the provider's billed charges as the Allowable Expense.	Medicare Estimation language will be added at the state level dependent on state requirements. Implementation of applying Medicare's allowed amount will apply upon renewal effective July 1, 2023. For new groups this was effective and implemented Jan. 1, 2023. 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 How Are Benefits Paid When You Are Medicare Eligible? in Section 8: General Legal Provisions for more information about how Medicare may affect your Benefits. When calculating the Coverage Plan's Benefit in these situations, we use Medicare's approved amount or Medicare's limiting charge. **UM Letter:** When a covered person is eligible for Medicare on a primary basis but chooses not to enroll in Medicare, the policy will pay as secondary and benefits will be calculated using Medicare's approved amount or Medicare's limiting charge.

Changes to Program Options and Services

Topic	Current Benefit	Renewing Benefit
MSK Low Back Pain	MSK (Musculoskeletal) Low Back Pain program allows for a combination of 3 visits for Physical Therapy or Spinal Manipulation for low back pain with no cost share to the member (including deductible). MSK visits accumulate to the annual therapy visit limits.	The MSK (Musculoskeletal) Low Back Pain program is being discontinued for all plans effective July 1, 2023, for large group. **UM Letter:** The rehabilitation cost share will apply to all visits, including the first 3 visits, for any combination of manipulative treatment and physical therapy for new low back pain.
UnitedHealthcare Rewards	New program	The UnitedHealthcare Rewards program provides the opportunity to receive rewards for achieving various activities with a maximum reward. The UnitedHealthcare Rewards core option will be embedded for small group. Health plans will have the option to include the premium option. UnitedHealthcare Rewards is a brand-new, market-leading program that combines components from UnitedHealthcare Motion® and SimplyEngaged® with other new innovations. This new program will provide for members a streamlined experience with more ways to earn rewards across numerous activities. UnitedHealthcare Rewards will replace Motion and SimplyEngaged (if included) for current groups with those programs. **UM Letter:** UHC Rewards is included. UHC Rewards is a digital wellness and rewards program that provides the opportunity for eligible members to receive rewards for achieving certain goals. Some examples of goals include completing 30 minutes of activity or steps per day, completing a biometric screening, participating in programs like Real Appeal®, signing up for a flu shot, or taking a health assessment. If you have Motion and/or SimplyEngaged programs, they are no longer available.

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Changes to Program Options and Services

Topic	Current Benefit	Renewing Benefit
Mineral™ (formerly known as ThinkHR) Administrative Services Exhibit	New program	Mineral (formerly known as ThinkHR) is a Compliance and Risk Management Service that provides HR type services. They help facilitate end to end HR solutions with technology, compliance content and expertise that many small employers don't typically have access to. This is filed in some states for both large group and small group. Expanding to additional large group states: FL ND SD UT The Group agrees to purchase additional administrative services provided by us or a vendor acting on our behalf. These services include basic guidance related to the Group's provision of benefits to its employees, including Benefits provided to Subscribers under the Group Policy, that may extend beyond the administrative services provided by us in administering the Group Policy, and includes the following: • State-specific benefit requirements for multi-state employers • Federal wellness program requirements • Compliance with the Employee Retirement Income Security Act (ERISA) • Health Savings Accounts (HSA) compliance and updates • Flexible Spending Accounts (FSA) • Wellness awareness and training • Compliance with employer obligations related to the Affordable Care Act (ACA) • Compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and state continuation requirements • Health Insurance Portability and Accountability Act (HIPAA) training • Benefit content and notices for employees • Compensation and benefit policies and program training **UM Letter:** An administrative services exhibit is included in your policy outlining additional services we will provide to you. These services include basic information related to the provision of benefits to your employees, including benefits provided to subscribers under the group policy, that may extend beyond the administrative services provided by us in administering that policy, such as, providing general information on requirements related to state benefits for multi-state employers, the Employee Retirement Income Security Act (ERISA), Health Savings Accounts (HSA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Affordable Care Act (ACA) as well as information on wellness and Health Insurance Portability and Accountability Act (HIPAA) training. You are required to pay for these services from your own funds and not from subscriber contributions.

continued

Changes to Program Options and Services

Topic	Current Benefit	Renewing Benefit
Doula Support Program	New program	A Doula is a non-licensed, non-clinical birth coach who provides continuous emotional, informational and physical support to a mother before, during and after labor. This is a wellness benefit and not a medical benefit, does not replace medical professional services. UnitedHealthcare will not provide a Doula network, it is up to the member to locate a Doula of choice. Members are responsible for up-front costs. Doula services are reimbursed by submitting receipts and a reimbursement form. The Doula Support Program provides an allowance for a Covered Person for the purpose of providing physical, informational, and emotional doula support during the Covered Person's pregnancy, childbirth, and the postpartum period. Services are only available for a Covered Person who is pregnant. This program provides an allowance for incurred doula support expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $1,500 per Covered Person per pregnancy will be provided for doula support. For the purposes of this Rider, "doula support" means physical, informational and emotional support provided directly by the doula. If you would like additional information regarding the Doula Support Program, you may contact us at [www.myuhc.com] [or] the telephone number on your health plan ID card. **UM Letter:** An allowance for incurred doula support expenses is provided up to $1,500 per covered person per pregnancy.
Self-Care formerly known as Sanvello®	Program transition	The Sanvello app will be transitioning to the Self Care app by AbleTo®. Self Care includes many of the same features and benefits as the Sanvello app, and members will still have access at no additional cost to them. Existing members will be prompted through the app to transition to Self-Care, and new members will be directed to Self-Care to access the app. The following states will require a rider to be filed: DC, MD, VA, WV, PA and NY. All other states will continue to have this program with the new name, and the Health Education generic language applies instead of the rider. **UM Letter:** The Sanvello app will be transitioning to the Self Care app by AbleTo, which includes many of the same features, such as meditation/mindfulness exercises and health/habit tracking.

New Prescription Drug Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
Biosimilar Product Provision	N/A	What Happens When a Biosimilar Product Becomes Available for a Reference Product? If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product. **UM Letter:** When biosimilars become available, pharmacy tiers may change for reference products or the reference products may be excluded.
Definition—Infertility	Infertility—not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination: • 1 year, if you are a female under age 35 • 6 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—not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination: • 1 year, if you are a female under age 35 • 6 months, if you are a female age 35 or older In addition, in order to be eligible for Benefits, you must also have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization. **UM Letter:** If infertility services are covered, eligibility for benefits no longer requires the member be a female under age 44.
Cosmetic and Convenience medications exclusion	Medications used for cosmetic purposes.	Medications used for cosmetic or convenience purposes. **UM Letter:** Convenience care medications are excluded.
Durable Medical Equipment - Diabetic Insulin Pumps	Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.	Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered. **UM Letter:** Durable Medical Equipment, including certain insulin pumps and related supplies, is excluded.

continued

New Prescription Drug Benefit Standards for ACA-compliant COC

Topic	Current Benefit	Renewing Benefit
Maintenance Medication Program	If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or 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 Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us 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 Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at a Retail Network Pharmacy.	If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy or 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 Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at [www.myuhc.com] or the telephone number on your ID card. **UM Letter:** Not required, this is a clarification.
Tobacco Cessation	Prescription Drug Products for tobacco cessation.	This exclusion is included if a group only excludes coverage for certain smoking cessation medications and the group is not subject to any essential health benefit requirements. Certain Prescription Drug Products for tobacco cessation. **UM Letter:** Certain prescription drug products for tobacco cessation are excluded.
Vital Medications Program (Zero Cost Share)	Covered at plan level benefit.	New initiative starting as early as Jan. 1, 2023. UnitedHealthcare will eliminate out-of-pocket costs on several preferred prescription drugs, including rapid- short- and long-acting insulins. In addition, four preferred vital medications will also have a $0 cost share: epinephrine (allergic reactions); glucagon (hypoglycemia); naloxone (opioid overuse); albuterol (asthma). This will become a new standard offering for all fully insured group plans beginning in 2023 and upon renewal. The $0 applies to co-pays and deductibles for all plans for these specific medications. Refer to Connect to Market site for supporting materials. **UM Letter:** Certain prescription drug products which are on the list of zero cost share medications located at myuhc.com are available at no cost share as permitted under state and federal law if obtained from any retail network pharmacy. These prescription drug products may also be available from a mail order network pharmacy. The list currently includes certain prescription drug products under the following drug classes or categories: insulins, epinephrine, glucagon, naloxone, albuterol inhalers and nebulized solutions.

Certificate of Coverage Consolidated Appropriations Act (CAA) changes summary

Consolidated Appropriations Act, PL 116-260 (the Act) the following apply for new and renewing groups as of July 1, 2023.

Topic	Benefit
Payment of Benefits - CAA	Addition of language to clarify the Payment of Benefits section 5 in the COC. **UM Letter:** 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.
Prior Authorization changes due to NSA	Removed the prior authorization requirement for out-of-network emergency admission for inpatient benefits. The following benefit categories are impacted: • Cellular and Gene Therapy • Habilitative Services • Hospital Inpatient • Mental Health Care and Substance-Related and Addictive Disorders Services • Reconstructive Procedures • Skilled Nursing Facility/Inpatient Rehab • Transplantation Services Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization 5 business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. **UM Letter:** For all inpatient benefits, the out-of-network prior authorization requirement has been removed for emergency admissions.
Allowed Amounts for Ground and Air Ambulances	Emergency Ambulance 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. IMPORTANT NOTICE: You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance 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 Certificate. 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. **UM Letter:** The allowed amount (which includes mileage) for emergency ground ambulance transportation provided by an out-of-network provider is a rate agreed upon by the provider or determined based upon the median amount negotiated with network providers for the same or similar service, unless a different amount is required by applicable law.

continued

Certificate of Coverage Consolidated Appropriations Act (CAA) changes summary

Consolidated Appropriations Act, PL 116-260 (the Act) the following apply for new and renewing groups as of July 1, 2023.

Topic	Benefit
Recognized Amount definition	**UM Letter:** Recognized amount is defined as the amount which copayment, coinsurance and applicable deductible is based upon when provided by out-of-network providers for either out-of-network emergency health care services, or non-emergency covered health care services received at certain network facilities by out-of-network providers, when such services are either ancillary services, or non-ancillary services that have not satisfied the required notice and consent criteria. The amount is based on one of the following in the order listed as applicable: an all payer model agreement if adopted, state law, or the lesser of the qualifying payment amount or the amount billed by the provider or facility. 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. Covered health care services that use the recognized amount to determine cost sharing may be higher or lower than if cost sharing for these covered health care services were determined based upon an allowed amount.

Product standards that are generally the same for the 2022 and 2023 ACA-compliant COC

- Ambulance Services
- Cellular and Gene Therapy
- Clinical Trials
- Congenital Heart Disease (CHD) Surgeries
- Dental Services Accident Only
- Diabetes Services
- Emergency Health Care Services - Outpatient
- Habilitative Services
- Home Health Care
- Hospice Care
- Hospital—Inpatient Stay
- Lab, X-Ray and Diagnostic-Outpatient
- Major Diagnostic and Imaging—Outpatient
- Ostomy Supplies
- Pharmaceutical Products—Outpatient
- Physician Fees for Surgical and Medical Services
- Physician's Office Services—Sickness and Injury
- Pregnancy—Maternity Services
- Preimplantation Genetic Testing and Related Services
- Preventive Care Services
- Prosthetic Devices
- Reconstructive Procedures
- Rehabilitation Services—Outpatient Therapy
- Scopic Procedures—Outpatient Diagnostic and Therapeutic
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
- Surgery—Outpatient
- Therapeutic Treatments—Outpatient
- Transplantation Services
- Urgent Care Center Services
- Virtual Care Services

United Healthcare

NOTE: The following benefit plan option is based on national standards. Applicable state-specific regulations will generally override these standards. Contact your UnitedHealthcare representative for more information. The benefit plan option changes the eligible expense for:

- Non-emergency inpatient or outpatient covered health services delivered by out-of-network emergency care physicians, anesthesiologists, radiologists and pathologists in network hospitals and ambulatory surgery centers (ASCs).
- Emergency inpatient or outpatient covered health services delivered by out-of-network emergency care physicians, anesthesiologists, radiologists and pathologists in either a network or out-of-network facility, including hospital and freestanding emergency rooms.

Reform requirements for prior authorization, out-of-network reimbursement and Essential Health Benefits (EHB) may vary by state.

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Doula Support is voluntary. The information provided under the program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional to determine what may be right for them. This program does not include a network of doulas, prescribe a doula's work or training requirements nor review a doula's qualifications. Individuals are solely responsible for selecting an appropriate doula and ensuring the doula is trained to their specifications to help meet their needs. Receiving reimbursement for incurred doula support expenses may have tax consequences. Individuals should consult an appropriate tax professional to determine whether they have any tax obligations from receiving reimbursement for these expenses under this program.

The AbleTo mobile application should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The Self Care information contained in the AbleTo mobile application is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used on its own as a substitute for care from a provider. AbleTo Self Care is available to members ages 13+ at no additional cost as part of your benefit plan. Self Care is not available for all groups in District of Columbia, Maryland, New York, Pennsylvania, Virginia or West Virginia and is subject to change. Refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card. Participation in the program is voluntary and subject to the terms of use contained in the mobile application.

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-855-256-8669 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA eligibility, as applicable. This program is not available in Hawaii, Kansas, Vermont and Puerto Rico. Components subject to change.

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

Members can visit the Find Physician, Laboratory or Facility section of the myuhc.com® member website to determine the network status of facility-based specialties of anesthesiology, radiology, pathology and emergency medicine. Although health care services may be provided to members at a health care facility that is in the UnitedHealthcare network, some professional services may be provided at or through the facility by physicians and other health care practitioners who are not in the UnitedHealthcare network. Members may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by the health benefit plan.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

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