UNITEDHEALTH GROUP®

UHG Benefits Handbook

Reimbursement, Voluntary, and Other Benefits

This document is the Benefits Handbook for the following UHG benefits plans:

- Family Care Flexible Spending Account
- Commuter Expense Reimbursement Account
- Critical Illness Insurance
- Accident Insurance
- Group Legal Insurance
- Adoption Assistance Plan
- Tuition Reimbursement Program
- Severance Pay Plan

The Importance of Defined Terms

Many of the terms used throughout the Handbook have specific meanings that are defined in the "Glossary" section.

To understand how the benefit plans work and to use your benefits effectively, we suggest that you take a few minutes to review all of the important terms in this Handbook.

If You Need Help Understanding This Benefits Handbook

This Handbook contains a summary of your rights and benefits under the plans offered by UHG. If you have difficulty understanding any part of this Handbook, contact HRdirect at 800-561-0861.

Language Assistance

- Help is available in Chinese if you live in San Francisco County, CA. Please call 800-561-0861.

  如果您居住在加州旧金山,可以获得中文协助。请于800-561-0861.

- Help is available in Tagalog if you live in Aleutians West Census Area and Aleutians East Borough Counties in AK. Please call 800-561-0861.

  Mayroong makukuhang tulong sa Tagalog kung ikaw ay nakatira sa Aleutians West Census Area at sa Aleutians East Borough Counties sa AK. Pakitawagan 800-561-0861.

- Help is available in Navajo if you live in Apache County, AZ, McKinley County, NM, or San Juan County, UT. Please call 800-561-0861.

  Tah dine'keh ji' yahti gho shi'ka a'dol wol niin ziin gho' Dziil ghaa ii beh woo'ji ha'ghii (Apache County), Hoozdoh ji doo , Yooto' altsi'gho ha'da'haasdzoo', ghii, (McKinley County, NM, or San Juan County, Ut), ee 'dii koh'ji' Ho'diil ni 800-561-0861.

- Help is available in Spanish. Please call 800-561-0861.

  Se ofrece ayuda en español. Por favor, llame al 800-561-0861.

Welcome to the UnitedHealth Group Incorporated Group Benefits Handbook (the Handbook or Benefits Handbook). UnitedHealth Group Incorporated (UnitedHealth Group, UHG, or the Company) has established the UHG Inc. Group Benefits Plan (the Plan), which includes certain component benefit plans summarized in this Handbook for your benefit and the benefit of your family if you are an eligible employee of the Company or a participating employer.

This Handbook is the first place you should turn when you have questions about the plans or the benefits described in this Handbook. Additional details about many of the plans are provided in official plan documents (which may include the Plan document, other documents, insurance contracts or policies, or the certificates for those component benefit plans). For those plans, if there is a discrepancy between the information in this Handbook and the official Plan document, the Plan document will govern.

The plan administrator has the sole discretion and authority to interpret the terms of the benefit plans, determine benefit eligibility, and resolve any and all ambiguities or inconsistencies in the benefit plans. Eligibility or participation in the benefit plans is not an offer or guarantee of employment or an employment contract. Receipt of this communication should not be considered to mean that you are a participant of or eligible to participate in any applicable benefit plan if you do not otherwise meet the eligibility requirements set forth in the documents that govern the applicable component benefit plan.

See the "Contact Information" section for important web addresses and phone numbers. If you have questions about your benefits, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

Important Note

This Handbook is effective January 1, 2021, and supersedes all prior versions of the Handbook, including all amendments.

The information in this document was updated as of January 1, 2021, and is subject to changes/ corrections/updates after this date. For the most current plan provisions or if you have questions about the information in this Handbook, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Governing Plan Documentation

The UHG Inc. Group Benefits Plan (the Plan) and each of its component benefit plans are governed by a formal plan document. Your rights are governed by the terms of that document. If there is any discrepancy between the formal plan document and this Handbook, the formal plan document will control. The formal plan document will also control in the event it is inconsistent with any Summary Plan Description (SPD) and certificate of coverage provided separately from this Handbook.

No person has the authority to make any oral or written statement or representation of any kind that is legally binding upon the Company that alters the Plan or any legal document maintained in conjunction with the Plan.

Summary Plan Descriptions (SPDs) for ERISA Plans

The component plans of the UHG Inc. Group Benefits Plan that are subject to ERISA must be summarized for you in an SPD. The following table identifies the documents that constitute the SPD for each ERISA-governed component benefit plan. The SPD may include sections of this Handbook and, for certain component benefit plans, the insurer's certificate of coverage and/or insurance policy. The Glossary is also part of the SPD, to the extent it defines terms used in Handbook sections that are part of an SPD.

Note that the Family Care Flexible Spending Account (Family Care FSA), Commuter Expense Reimbursement Account, Adoption Assistance Plan and Tuition Reimbursement Program are not subject to ERISA.

These documents are available on the Benefits Site at https://benefitsenroll.uhg.com.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

ERISA-Governed Component Plan	Benefits Handbook Sections or Other Documents That Comprise the SPD
Critical Illness Insurance	Handbook Sections ■ Introduction ■ Eligibility and Enrollment ■ Administrative Information Other Documents ■ Certificate of Coverage issued by UnitedHealthcare Insurance Company
Accident Insurance	Handbook Sections ■ Introduction ■ Eligibility and Enrollment ■ Administrative Information Other Documents ■ Certificate of Coverage issued by UnitedHealthcare Insurance Company
Group Legal Insurance	Handbook Sections ■ Introduction ■ Eligibility and Enrollment ■ Administrative Information Other Documents ■ MetLife Legal Plans® Summary Plan Description
Severance Pay Plan	Other Documents ■ UnitedHealth Group Severance Pay Plan and Summary Plan Description

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Your Rights under ERISA

See the "Administrative Information" section for more information about your ERISA rights.

If you participate in a non-ERISA plan, the ERISA rights and protections do not apply with regard to the non-ERISA plan benefits.

Plan Administrator

The UnitedHealth Group Employee Benefits Plans Administrative Committee (the Committee) serves as the plan administrator to the benefit plans described in this Handbook.

The plan administrator has the authority to delegate, and has delegated, certain authority and duties to other parties, who are third-party administrators, fiduciaries and/or trustees.

The plan administrator (and any other persons or entities to whom the plan administrator delegates discretionary authority and duties) has the sole and exclusive authority and discretion to interpret the benefit plans' terms and benefits under them, and to make factual and legal decisions about them.

Company's Reservation of Right to Amend and Terminate the Plan or Component Benefit Plans

UHG reserves the right to modify or amend, in whole or in part, or terminate any or all of the Plan or the component benefit plans discussed in this Handbook for any reason and in its sole discretion at any time. UHG's right to amend or terminate the benefit plans includes, but is not limited to, changes in the eligibility requirements, premiums or other employee payments charged, benefits provided, and termination of all or a portion of the coverages provided under the plans.

Amendments may be retroactive to the extent permitted under applicable law. Modification of the terms of the Plan or termination of the Plan will be effective only in writing and in compliance with the Plan's requirements for an amendment or termination of the Plan. Oral representation concerning the interpretation of the Plan will not be effective to amend the Plan or component benefit plans.

If a benefit plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. However, no amendment or termination will reduce the amount of any benefit otherwise payable under the Plan or a component benefit plan for charges incurred prior to the effective date of the amendment or termination.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan will terminate unless the Plan is continued by a successor to the Company.

If a benefit plan is terminated and surplus assets remain after all liabilities have been paid, the surplus will revert to the Company to the extent permitted under applicable law, unless otherwise stated in the insurance or administrative contract or otherwise determined by the Board of Directors of the Company.

Not an Employment Contract

Neither the receipt of this Handbook, nor the use of the term “you” means that you are eligible for a benefit under any of the component benefit plans that are summarized in the Handbook. You are eligible to participate in a component benefit plan or receive a benefit only if you satisfy the applicable eligibility requirements and other criteria. The receipt of this Handbook and/or the terms of the component benefit plans also neither create a right for you to be retained in employment nor prevent the Company from terminating your employment for any reason.

Questions?

If you have questions about your benefits, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

This section provides general information on who is eligible to participate in UHG benefits, when you can enroll, how you can change your benefit elections, how leaves of absence affect your benefits, the cost of coverage and when coverage ends.

See the applicable plan sections of this Handbook for eligibility and participation details specific to each component benefit plan.

In This Section — See Page

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

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Who Is Eligible

Participating Employers

The component benefit plans described in this Handbook are available to eligible employees of the following subsidiaries of the Company, all of which are considered participating employers:

- United HealthCare Services, Inc.;
- UHC International Services, Inc.;
- Health Plan of Nevada, Inc.;
- Sierra Health and Life Insurance Company, Inc.;
- Southwest Medical Associates, Inc.;
- Optum Services, Inc.;
- PrimeCare Medical Network, Inc.;
- Monarch Health Plan, Inc.;
- UnitedHealthcare of Illinois, Inc.;
- Optum Services Puerto Rico, LLC; and
- Any other employer that adopts the benefit plan(s), with UnitedHealth Group's written consent.

Important Note: Even though you may be an employee of a participating employer, throughout the Handbook, we refer to all employees as employees of UHG. Also note that most employees are employed by United HealthCare Services, Inc., or Optum Services, Inc., not the business segment with which they identify, such as UnitedHealthcare, OptumHealth, etc. This is why business segment names are not included on this list. If you are not sure which entity is your employer, you can find out by looking at your online paycheck on The Hub at https://hub.uhg.com, your biweekly paycheck or your deposit advice.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Eligible Employees

In general, you are an eligible employee if you work for a participating employer and are classified on both the U.S. payroll and the personnel records of the participating employer as one of the following classifications. Benefit plan eligibility is based on employee classification and/or geographical location. Please see the table in the "Benefits in Which Eligible Employees Can Participate" subsection for more information.

- **Regular full-time employee (not otherwise listed).** You are classified on both the payroll and the personnel records of the participating employer as a regular full-time employee regularly scheduled to work at least 35 hours per week.
- **Regular part-time employee (not otherwise listed).** You are classified on both the payroll and the personnel records of the participating employer as a regular part-time employee regularly scheduled to work at least 20 to 34 hours per week.
- **Regular part-time employee regularly scheduled to work fewer than 20 hours per week (not otherwise listed).** You are classified on both the payroll and the personnel records of the participating employer as a regular part-time employee regularly scheduled to work fewer than 20 hours per week.
- **Acquired employee during a transition year.** Eligibility depends on acquisition agreement.
- **Regular full-time employee from India on U.S. assignment greater than 12 months.** You are classified on the United States payroll and the personnel records of the participating employer and you are assigned by UHG to work inside the United States for longer than 12 months.
- **Regular employee of Optum Services Puerto Rico, LLC in Puerto Rico.** You are classified on both the payroll and the personnel records of the participating employer as a regular full-time employee regularly scheduled to work at least 35 hours per week in Puerto Rico, a regular part-time employee regularly scheduled to work at least 20 to 34 hours per week in Puerto Rico or as a regular part-time employee regularly scheduled to work fewer than 20 hours per week in Puerto Rico.
- **Regular full-time employee on overseas assignment for six months or more.** You are classified on both the U.S. payroll and the personnel records of the participating employer and you are assigned by UHG to work outside the United States for at least six months.
- **Regular full-time employee from India on U.S. assignment three months to 12 months.** You are classified on the India payroll and the personnel records of the participating employer, and you are assigned by UHG to work inside the United States for at least three months to 12 months.
- **Temporary employee.** You are classified on both the payroll and the personnel records of the participating employer as a temporary employee, which includes per diem and seasonal employees.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Special Eligibility Rules

The following sections and summaries explain their special eligibility rules in more detail:

- Family Care Flexible Spending Account (Family Care FSA)
- Commuter Expense Reimbursement Account (CERA)
- Critical Illness Insurance
- Accident Insurance
- Group Legal Insurance
- Adoption Assistance Plan
- Tuition Reimbursement Program
- Severance Pay Plan

Classification Rule

UHG determines who is eligible to participate in its benefit plans. In making that determination, UHG classifies employees as eligible or ineligible for benefits. This classification is final, binding and conclusive. No reclassification of a person's status by a third party for any reason, whether by a court, governmental agency or someone else, without regard to whether or not UHG agrees to such reclassification, will make the person retroactively or prospectively eligible for benefits. However, UHG, in its sole discretion, may reclassify a person as a benefits-eligible employee for future periods. If there is any question or uncertainty about a person's classification, the person will be treated as ineligible for benefits.

Who Is Not an Eligible Employee

You are not an eligible employee and are not eligible to participate in any of the benefit plans described in this Handbook if you are employed by a company that is not a participating employer in a specific benefit plan, or, even if you are employed by a participating employer, you are classified on both the payroll and the personnel records of the participating employer as any one or more of the following (unless otherwise described in the Eligible Employees list above):

- A temporary employee, except for the following:
  - A temporary employee can participate in the Commuter Expense Reimbursement Account
- An employee whose terms and conditions of employment are subject to a collective bargaining agreement (unless the collective bargaining agreement specifically provides for participation in a specific plan or program) and except as provided for in the "Benefits in Which Eligible Employees Can Participate" subsection

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- A United States citizen or resident performing services outside of the United States, unless approved by the Company
- A nonresident alien who is not identified as an exception in the "Benefits in Which Eligible Employees Can Participate" subsection
- A leased employee, an independent contractor or any other person whom the Company has not classified as a common-law employee, except for the following:
  - Individuals not classified as employees are eligible to elect to continue Family Care FSA coverage after termination of employment.
  - The Company may offer leased employees, independent contractors or other non-employees coverage under the Plan to the extent required under a purchase agreement, merger or acquisition or other contractual arrangement.

Benefits in Which Eligible Employees Can Participate

The following table shows the component benefit plans, by eligible employee class, available to eligible employees. If a benefit plan is not listed in this table as being available to a specific eligible employee class, that class is not eligible to participate in the plan.

Eligible Employee Class	Component Benefit Plans in Which the Eligible Employee Can Participate
Regular Full-Time Employee ***(not otherwise listed in this table)*** ***Regular Part-Time Employee scheduled to work 20–34 hours per week*** ***(not otherwise listed in this table)*** ***Regular Full-Time Employee from India on U.S. Assignment greater than 12 months*** ***Regular Full-time Employee on Overseas Assignment for six months or more*** ***(eligibility generally remains unchanged)***	■ Family Care FSA ■ CERA (U.S. expenses only) ■ Critical Illness Insurance ■ Accident Insurance ■ Group Legal Insurance ■ Adoption Assistance Plan ■ Tuition Reimbursement Program ■ Severance Pay Plan
Regular Part-Time Employee regularly scheduled to work fewer than 20 hours per week ***(not otherwise listed in this table)***	■ CERA ■ Group Legal Insurance ■ Severance Pay Plan
Acquired Employee during a Transition Year	■ Depends on acquisition agreement
Regular Employee of Optum Services Puerto Rico, LLC ***(regularly scheduled to work at least 20 hours per week in Puerto Rico)***	■ Adoption Assistance Plan ■ Tuition Reimbursement Program

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Eligible Employee Class	Component Benefit Plans in Which the Eligible Employee Can Participate
Temporary (including Per Diem and Seasonal) Employee You are classified on both the payroll and the personnel records of the participating employer as a temporary employee, which includes per diem and seasonal employees.	■ CERA

Employees Hired during an Acquisition

Acquired employees, hired as a direct result of an acquisition, are eligible to participate in the Company's benefit plans if, after the acquisition, they are employed by a participating employer and classified on both the participating employer's payroll and personnel records in one of the eligible employee classes. If acquired employees are eligible for a legacy plan of the acquired company, then they are not eligible for the UHG Inc. Group Benefits Plan.

The participation dates and benefit plans in which acquired employees are eligible to participate vary depending on the acquisition, and are set forth in the Transition Guide and Calendar or similar document for each acquisition and/or in separate materials that are provided to acquired employees shortly before they become eligible to participate.

Eligible Dependents

To be eligible for coverage, your dependent must reside in the United States and meet the following requirements. Your eligible dependents may include your:

- **Spouse.** Your spouse is the person of the same or opposite gender to whom you are legally married and maintain a shared financial responsibility to each other. This includes your common-law spouse in states where it is recognized. (A former spouse, a spouse from whom you are legally separated or a spouse with respect to whom an annulment or decree of separate maintenance is in effect is not your spouse); ***or***
- **Domestic Partner.** A person of the same or opposite gender is your domestic partner if you and your domestic partner maintain a shared financial responsibility to each other and meet one of the following two rules:
  - You and your domestic partner have registered your domestic partnership in a state or other locality that provides such a registration process and your registered domestic partnership has not been dissolved, annulled or otherwise terminated; ***or***

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- Your relationship satisfies **all** of the following requirements:
  - You and your domestic partner have lived together in an exclusive relationship for at least one year, and intend to keep doing so for a long-lasting and indefinite time period;
  - You and your domestic partner are not legally barred from entering into a marriage relationship for reasons of an existing marriage, age, mental competency or blood relationship;
  - Neither you nor your domestic partner is in a domestic partnership with anyone else;
  - You and your domestic partner have not entered into a domestic partnership solely for the purpose of obtaining benefits; ***and***
  - Neither you nor your domestic partner has notified the Company that your domestic partnership has been terminated.

- **Dependent Child.** Any child who is the biological child, legally adopted child, or stepchild of you and/or your spouse or domestic partner, and any child who is placed in your home for legal adoption by you and/or your spouse or domestic partner or for whom you and/or your spouse or domestic partner have legal guardianship or a foster child, if the child is under age 26.

  You may cover a grandchild of either you or your covered spouse or domestic partner, provided the grandchild is under age 26 and is financially dependent upon and resides with you or your spouse or domestic partner. You must claim your grandchild as a dependent on your federal tax return for the calendar year for which you are providing coverage to the grandchild, and your grandchild must meet all of the following eligibility requirements:
  - Provides no more than one-half of his or her own financial support for the year;
  - Has your home as his or her principal place of abode for more than one-half of the year (for this purpose, temporary absences because of illness, education, vacation or military service do not reduce the child's period of residence); and
  - Is under age 26.
- **Disabled Dependent Children.** For any child who otherwise satisfies the requirements to be a dependent child, coverage can extend beyond age 26 if all of the following additional requirements are met:
  - The child is severely disabled by permanent physical or mental incapacity (medical proof of disability is required);
  - The child becomes disabled prior to attaining age 26 and while covered under the Company's insurance plans or the child became disabled prior to attaining age 26 and while covered under another group insurance plan and lost coverage under another group plan;
  - The child remains unmarried and dependent on you for support because he or she is incapable of earning a living due to the disability; and
  - The child is incapable of caring for himself or herself due to the disability.
  - Determinations of disability and continued coverage are made by UnitedHealthcare.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

To apply for this special coverage, you will need to complete the "Statement of Dependent Eligibility beyond Limiting Age Due to Mental or Physical Disability" form. You must file the completed form with the respective carrier/insurer no later than 60 days after any of the following: the date the child would otherwise lose coverage under the Plan, your hire or acquired date, or the loss of other group insurance. Call HRdirect at 800-561-0861 to request the form and start the approval process.

In addition to any other provisions in the Handbook that would cause a disabled child to lose coverage, coverage for a disabled child will cease on the date the first of the following occurs:

- Cessation of the disability;
- Failure to give proof upon request that the disability continues;
- Failure to have any required exam and/or to participate in any recommended course of treatment;
- Termination of dependent coverage of the child for any reason other than reaching the maximum age;
- Termination of your coverage for any reason;
- Amendment of the component benefit plans to eliminate disabled dependent child coverage; or
- Termination of the component benefit plans.

If Your Spouse or Domestic Partner or Dependent Child Also Works at the Company

If you and your spouse or domestic partner or dependent child both work at and are eligible employees at the Company, you cannot be covered as both an employee and a dependent under most of the Company component benefit programs.

For the Dependent Care Reimbursement Account of the Family Care FSA, note that the combined contribution total for each cannot exceed the federal maximum per year, if you file taxes jointly.

People Who Are Not Eligible Dependents

The following people are not eligible dependents, and you cannot enroll them or request benefits with respect to them in UHG's benefit plans:

- Former spouses, a spouse from whom you are legally separated, or a spouse with respect to whom an annulment or decree of separate maintenance is in effect, and/or former domestic partners;
- Parents;
- Sisters and brothers;
- Aunts, uncles and cousins;
- Friends and neighbors; and
- Nannies, au pairs or other caregivers.

This list is not all-inclusive and merely identifies the more commonly encountered people who cannot be enrolled in these component benefit plans.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Proof of Dependent Eligibility

You will be asked upon initial enrollment and from time to time to provide proof that your dependent is or remains an eligible dependent. UHG reserves the right, in its sole discretion, to decide what forms of support are acceptable as proof. Failure to timely provide requested documentation may result in termination of coverage for the enrolled individual(s). See "Dependent Eligibility Rules and Requirements" on the Benefits Site at https://benefitsenroll.uhg.com.

If UHG determines that you have enrolled a person who is not your eligible dependent, UHG reserves the right to take action, including but not limited to terminating coverage and recovering any benefits that were paid, and/or terminating your employment.

Enrolling for Coverage

The "What You Need to Know to Enroll" subsection applies to eligible employees who are not acquired employees, and summarizes when they can first be eligible for coverage in the various benefit plans, and, where applicable, their initial enrollment deadlines and subsequent regular opportunities to make enrollment changes.

How to Enroll

To enroll in coverage under the Company's health and welfare component benefit plans for the first time:

- **Read Your Benefits Resources.** Visit the Benefits Site at https://benefitsenroll.uhg.com and review the benefits information and this Benefits Handbook.
- **Enroll Online.** Complete the benefits enrollment process online on or before your enrollment deadline on the Benefits Site at https://benefitsenroll.uhg.com. If you're a first-time user, you'll need the employee ID number that UHG assigns to you, and the last four digits of your Social Security number.
- **Enroll by Phone If You Don't Have Internet Access.** Complete the benefits enrollment process on or before your enrollment deadline by calling HRdirect at 800-561-0861 and speaking to a Benefits Advisor.

Initial Enrollment Deadline

For the Company benefit plans that require you to pay all or a portion of the cost, you must take action to enroll if you want to participate in them, and must do so by a particular date that we refer to as the initial enrollment deadline. Typically, this deadline is 30 days from your hire date. However, for some of the benefit plans, you do not need to enroll, because coverage under them is automatic. Note that any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your coverage effective date.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

When Coverage Begins

For many of the benefit plans, you must enroll online or contact HRdirect during the 30-day period before your initial enrollment deadline or during an annual Open Enrollment Period in order for your coverage to be effective. Your coverage begins on your coverage effective date. You may have more than one coverage effective date depending on your status and the benefit plan. This table outlines "What You Need to Know to Enroll" for the coverage effective date, enrollment deadlines, and some things to consider as you make your election decisions for each benefit plan.

Important Note: This table does not summarize midyear life events, which are discussed in the "Life Events and the Consistency Rule" subsection. Different rules apply to acquired employees, which are explained in the Transition Guide and Calendar or similar document for each acquisition and/or in separate materials that are provided to acquired employees shortly before they become eligible to participate.

What You Need to Know to Enroll

Benefit Plan or Program	When Coverage Begins – Coverage Effective Date	Regular Enrollment Deadlines	Things to Consider
Family Care FSA	■ If you are a newly hired eligible employee, or are rehired after 30 days of your last employment with UHG, the first day of the month following your hire date.* ■ If you are rehired *within* 30 days of your last employment with UHG, (within the same calendar year), your *previous elections (same contribution election) will be reinstated.* ■ If you are reclassified as an eligible employee, the first day of the month following the date your reclassification is effective.**	■ You must enroll on or before your initial enrollment deadline (the 30th day following your hire date or reclassification as an eligible employee), or during the annual Open Enrollment Period.	Expenses for dependent children age 13 or older are not eligible for reimbursement unless the children are otherwise considered qualified dependents. See the definitions for "Family Care FSA/ Dependent Care Reimbursement Account (DCRA) Dependent Child" and "Eligible Dependent Care Expenses" in the "Glossary" section.

* The enrollment election process for an employee rehired after 30 days follows the New Hire process.

**For a regular full-time employee on overseas assignment for six months or more who becomes an eligible employee, such employee's coverage effective date is the date the employee's reclassification is effective.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plan or Program	When Coverage Begins – Coverage Effective Date	Regular Enrollment Deadlines	Things to Consider
CERA	■ If you enroll by the 10th of the month, you begin to participate on the first day of the following month.	■ You may enroll or change your CERA contribution at any time. ■ If you enroll by the 10th of the month, you begin to participate on the first day of the following month.	Not applicable.
Critical Illness Insurance	■ If you are a newly hired eligible employee, or are rehired after 30 days of your last employment with UHG, the first day of the month following your hire date.* ■ If you are rehired *within* 30 days of your last employment with UHG (within the same calendar year), your *previous elections (same contribution election) will be reinstated.* ■ If you are reclassified as an eligible employee, the first day of the month following the date your reclassification is effective.**	■ You may enroll on or before your initial enrollment deadline (the 30th day following your hire date, probationary period or reclassification as an eligible employee) or during an annual Open Enrollment Period.	Not applicable.

* The enrollment election process for an employee rehired after 30 days follows the New Hire process.
** For a regular full-time employee on overseas assignment for six months or more who becomes an eligible employee, such employee's coverage effective date is the date the employee's reclassification is effective.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plan or Program	When Coverage Begins – Coverage Effective Date	Regular Enrollment Deadlines	Things to Consider
Accident Insurance	■ If you are a newly hired eligible employee, or are rehired after 30 days of your last employment with UHG, the first day of the month following your hire date.* ■ If you are rehired *within* 30 days of your last employment with UHG (within the same calendar year), your *previous elections (same contribution election) will be reinstated.* ■ If you are reclassified as an eligible employee, the first day of the month following the date your reclassification is effective.**	■ You may enroll on or before your initial enrollment deadline (the 30th day following your hire date, probationary period or reclassification as an eligible employee) or during an annual Open Enrollment Period.	Not applicable.

* The enrollment election process for an employee rehired after 30 days follows the New Hire process.
** For a regular full-time employee on overseas assignment for six months or more who becomes an eligible employee, such employee's coverage effective date is the date the employee's reclassification is effective.
Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plan or Program	When Coverage Begins – Coverage Effective Date	Regular Enrollment Deadlines	Things to Consider
Group Legal Insurance	■ If you are a newly hired eligible employee, or are rehired after 30 days of your last employment with UHG, the first day of the month following your hire date.* ■ If you are rehired *within* 30 days of your last employment with UHG (within the same calendar year), your *previous elections (same contribution election) will be reinstated.* ■ If you are reclassified as an eligible employee, the day your reclassification is effective.**	■ You may enroll on or before your initial enrollment deadline (the 30th day following your hire date, probationary period or reclassification as an eligible employee) or during an annual Open Enrollment Period.	Not applicable.
Adoption Assistance Plan	■ If you are a newly hired eligible employee, or are rehired after 30 days of your last employment with UHG, the first day of the month following your hire date.* ■ If you are reclassified as an eligible employee, the first day of the month following the date your reclassification is effective.**	■ You do not need to enroll.	■ If you adopt, you will need to submit claims for eligible expenses. You must be an active employee at the time the adoption is completed.

* The enrollment election process for an employee rehired after 30 days follows the New Hire process.
** For a regular full-time employee on overseas assignment for six months or more who becomes an eligible employee, such employee's coverage effective date is the date the employee's reclassification is effective.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plan or Program	When Coverage Begins – Coverage Effective Date	Regular Enrollment Deadlines	Things to Consider
Tuition Reimbursement Program	■ If you are an eligible employee, your coverage begins automatically the day following the six-month anniversary of your hire date or date of reclassification as an eligible employee.	■ You do not need to enroll.	■ If you want to take a course, you must receive preapproval, and you will need to submit claims for eligible expenses.
Severance Pay Plan	■ If you are a newly hired eligible employee, your hire date. ■ If you are reclassified as an eligible employee, the day your reclassification is effective.	■ You are automatically covered.	Not applicable.

Changing Your Benefit Elections

Annual Open Enrollment Period

- During the annual Open Enrollment Period, you have the opportunity to change your elections for the next calendar plan year for many of the benefits described in this Handbook. The annual Open Enrollment Period typically takes place in October, but may vary from year to year. Shortly before it begins, you will receive an email notification providing direction to enrollment materials that will help you make these decisions for you and your family. The enrollment materials describe the enrollment process, the actions you need to take, the deadlines that apply and what happens if you don't take action.
- The elections you make during the annual Open Enrollment Period go into effect on January 1 of the following calendar year, and remain in effect for the calendar year. Many of these elections cannot be changed midyear unless you experience a life event. The life event rules are explained in the "Changing Elections Midyear" subsection.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Changing Elections during Annual Open Enrollment

For your convenience, the Company may carry over your elections during annual Open Enrollment (except for the Family Care FSA, which does not carry over). It is your responsibility to read UHG's annual Open Enrollment communications to understand whether you need to take action to make changes and the deadlines for making your elections.

The benefit plans under which you can change your elections during an annual Open Enrollment Period include:

- Family Care FSA
- Accident Insurance
- Critical Illness Insurance
- Group Legal Insurance

Changing Elections Midyear

See also the "Life Events" section.

As a general rule, for benefit plans for which you make pre-tax contributions, federal tax law requires that once you make an election for you and your eligible dependents to be covered or not covered under the plan, that election is irrevocable and must remain in effect through December 31 of the year for which it was made. There are exceptions to this rule, however, and midyear changes to your elections for these pre-tax benefits are permitted when you experience certain life events and meet the consistency rule.

For the benefit plans for which you make after-tax contributions, and the CERA, you do not need to experience a life event or meet the consistency rule to make a midyear change in your coverage election; you may change your election at any time during the year subject to rules and conditions of the benefit plan. Refer to the applicable sections in this Handbook for more information.

For the CERA

If you enroll by the 10th of the month, your participation begins on the first day of the following month. CERA deductions are taken from your second paycheck of the month.

CERA is a month-to-month benefit that allows you to start and stop any month of the year, including the annual Open Enrollment Period. To cancel your benefits, you must do so by the 10th of the month for the cancellation to be effective the next month.

For Critical Illness Insurance

You may change your tobacco-use status for your Critical Illness Insurance premiums at any time during the year. You and/or your spouse/domestic partner must be tobacco-free for at least 12 months in order to elect the tobacco-free premiums. Your premium will change prospectively the first of the month following the date you change your tobacco-use status.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Life Events and the Consistency Rule

Life Events Rule

Midyear changes to your elections for Accident Insurance, Critical Illness Insurance and the Family Care FSA are permitted only when:

- You experience a life event;
- Your desired change satisfies the consistency rule, if any, that applies to it; and
- You elect the change by the applicable deadline.

Additional Limitations

While the "Life Events" section summarizes most of the rules that apply to your ability to change your elections for coverage under the benefit plans, it does not address all of the possible life event situations that you may encounter. Additional limitations may be imposed on your ability to make midyear changes as a result of certain life events. If you have questions regarding a change you wish to make to your benefit elections, you can contact HRdirect at 800-561-0861.

Consistency Rule

The tables in the "Life Events" section identify:

- The life events that permit you to change your coverage election midyear under these plans; and
- The general consistency rule that requires that the change you elect be both on account of and consistent with the life event that affects your or your eligible dependent's eligibility for coverage.

Consistency rules vary for different types of benefits, and in some cases, special consistency rules apply to some of the life events.

For illustrations of how the consistency rule applies to several events that commonly occur in your work and home life, refer to the "Life Events" section.

Election Changes Deadline and Effective Date

Deadline for Election Changes

Generally, you must elect a change as a result of a life event during the 30-day period beginning on the date the life event occurs (60 days for a birth or adoption, divorce, or eligible dependent loses eligibility life event). See the "Life Events" section for details on the election deadlines for each event. If you do not elect your change within this time period, you will not be permitted to make the change.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

For some life events, you will need to contact HRdirect at 800-561-0861. You may be required to provide supporting documentation substantiating the life event.

For the life events that result in the loss of eligibility for coverage under one or more of the benefit plans (i.e., your divorce, or your eligible dependent otherwise loses eligibility), if you don't complete your election change online or contact HRdirect before the applicable deadline, premiums or contributions will continue to be deducted from your pay. Upon receiving notification of a previously eligible dependent being ineligible under a benefit plan, the Company reserves the right to cancel the ineligible person's coverage retroactively and refund premiums for the period of ineligibility. If you notify HRdirect after the deadline, the date of your notice will be considered the date of the event and coverage for the ineligible person will end on the last day of the month. Continuation coverage will not be offered. Premiums will not be refunded.

Effective Date of Election Changes

For most life events, your new election will be effective on the first day of the month following the date of the event. However, if the life event is the birth, adoption or placement for adoption of a child, your new coverage election will be effective on the date the life event occurred.

Automatic Changes to Benefit Elections

In some situations, you do not need to request a change to your Family Care FSA pre-tax benefit elections; they will be changed for you automatically. These situations include the following status changes or life events:

- **Your employment ends or you otherwise lose eligibility.** Your pre-tax benefit elections terminate automatically as of the last day of the month in which your employment ends or you otherwise lose eligibility.

Eligibility Appeals

If you believe your eligibility or election to participate in a benefit plan has been administered improperly or denied incorrectly, you may request a review of the eligibility determination by contacting HRdirect at 800-561-0861 within 60 days of the denial. A decision will be provided within 60 days if all information needed to make a decision is provided. If you disagree with the review and response, you may request a final review by filing a written appeal with the plan administrator by contacting HRdirect at 800-561-0861 within 60 days of the date of the first-level denial letter. The plan administrator's Health & Welfare Claims Review Sub-Committee will review the facts, the reasons for the decision, and the information provided, and provide a decision within 60 days following their receipt of the appeal. If the plan administrator needs additional time to make a decision on your appeal, you will be notified in writing. The decision of the Health & Welfare Claims Review Sub-Committee is final and binding.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

When Coverage Ends

For Eligible Employees

Generally, your coverage under the Family Care FSA, Critical Illness Insurance, Accident Insurance, and Group Legal Insurance automatically ends on the last day of the month in which the earliest of the following occurs (unless otherwise noted):

- The Company amends or terminates the benefit plan or program for any reason;
- Your employment with UHG ends for any reason (including retirement);
- You fail to pay required contributions when they are due, in which case coverage ends the date for which you last paid required contributions;
- For Critical Illness and Accident Insurance, after 60 months of you being a member of the armed forces on active duty; or
- You cease to be eligible to participate in the specific benefit plan or program.

Note: For the Family Care FSA, you can continue to submit eligible claims incurred until the end of the calendar year in which your contributions ended — up to the balance in your Family Care FSA (dependent care reimbursement account).

Your coverage under the CERA, Severance Pay Plan, Adoption Assistance Plan and Tuition Reimbursement Program ends on the date the earliest of the following occurs:

- The Company amends or terminates the benefit plan or program for any reason;
- Your employment with UHG ends for any reason (including retirement);
- You fail to pay required contributions when they are due, in which case coverage ends on the date for which you last paid required contributions; or
- You cease to be eligible to participate in the specific benefit plan or program.

For Eligible Dependents

Generally, your eligible dependents' coverage under the Reimbursement, Voluntary, and Other Benefits Plans automatically ends on the last day of the month in which the earliest of the following occurs (unless otherwise noted):

- UHG terminates the benefit plan or program for any reason;
- Your employment with UHG ends for any reason (including retirement);
- You fail to pay required contributions when they are due, in which case coverage ends the date for which you last paid required contributions;

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- For Critical Illness and Accident Insurance, after 60 months of your covered eligible dependent being a member of the armed forces on active duty;
- You cease to be eligible to participate in the specific benefit plan or program; or
- Your eligible dependent ceases to be an eligible dependent (including when your dependent child becomes age 26).

For Both Eligible Employees and Eligible Dependents

The plan administrator will provide prior written notice to you that your coverage will end on the date identified in the notice if you or your covered eligible dependent:

- Commits an act, practice or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent;
- Commits an act of physical or verbal abuse that imposes a threat to the plan administrator's staff, UnitedHealthcare's staff, a provider or another covered person.

Additional Information on When Coverage Ends for Critical Illness Insurance and Accident Insurance

Your Critical Illness Insurance and Accident Insurance will end on the date that is determined by the plan administrator in its discretion, if you:

- Engage in or permit or assist another in committing fraud and/or in submit false information regarding eligibility for coverage or payment of benefits; or
- Violate the terms of the plan.

Note: In addition to termination of coverage, the Company may also take appropriate disciplinary actions, up to and including termination of employment.

Leaves of Absence

In general, your benefits continue while you are on a leave of absence and require continued premium remittance for the continuation. If you receive pay through Short-Term Disability (STD) or Paid Time Off (PTO), your benefit deductions will continue to be withheld from your paycheck. For the period of any unpaid leave of absence less than six months, missed premium deductions will accumulate in arrears until your paychecks resume.

After six months, we no longer support paycheck deductions. If you remain out on a leave of absence longer than six months, you must submit monthly benefit premiums through a direct bill process. You will be mailed a letter to your home address with instructions for payment and premium information.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

For more information about the impact of a leave of absence on your benefit plan coverage, see "Benefits During a Leave of Absence," located on the The Hub under "Policies" and "Leaves and Disability" at https://hub.uhg.com. These events include:

- Receiving disability benefits and are still employed by UHG.
- Taking a leave of absence.
- Taking leave under the Family and Medical Leave Act (FMLA).

For Critical Illness Insurance and Accident Insurance

If the covered person is on Family or Medical Leave of Absence, or other leave of absence required by an applicable state or federal law, continuation of his or her insurance will be governed by the Company's policy on such leave, not to exceed the greater of:

- The leave period required by the Family and Medical Leave Act of 1993 (FMLA); or
- The minimum leave period required by applicable state law.

If You Become Disabled

If you become disabled, notify your supervisor and call Sedgwick immediately. The following table outlines how your benefits coverage is affected by becoming disabled and not actively at work. See the *Disability and Life* Handbook for more information.

If You Take an Approved Paid Leave of Absence

If you plan to take a Company-approved leave of absence, your benefits generally will continue. If you take a paid leave, your contributions will continue to be taken out of your paycheck.

If You Take an Approved Unpaid Leave of Absence

If you take an approved unpaid leave of absence, your benefits will continue and any missed premium deductions will accumulate in arrears until your paychecks resume.

Military Leave
If you take a military leave, see the Military Leave of Absence policy on The Hub under Policies at https://hub.uhg.com/policies/human-capital/leaves-disability/Military-Leave-Absence/272.

Coverage continues during your military leave unless you gain coverage through the military and timely request a life event change through HRdirect during the 30-day period beginning on the date you gain military coverage.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

You can make certain changes consistent with the unpaid leave of absence.

Benefit Plans	What Happens to Your Coverage during an Approved Unpaid Leave of Absence
Family Care FSA	■ Your contributions will stop during your leave.
Critical Illness Insurance	■ Coverage continues as long as you continue to pay premiums. ■ You can elect to cancel your coverage. ■ When you start an FMLA leave, you may cancel coverage. Coverage can be reinstated prospectively when you return from the FMLA leave.
Accident Insurance	■ Coverage continues as long as you continue to pay premiums. ■ You can elect to cancel your coverage. ■ When you start an FMLA leave, you may cancel coverage. Coverage can be reinstated prospectively when you return from the FMLA leave.
Group Legal Insurance	■ Coverage continues as long as you continue to pay premiums. ■ You can elect to cancel your coverage. ■ When you start an FMLA leave, you may cancel coverage. Coverage can be reinstated prospectively when you return from the FMLA leave.

Cost of Coverage and Benefits

The Company makes a substantial investment in the benefit programs we offer. For some benefit plans, UHG pays the entire cost of coverage. For others, you and UHG share in the cost of coverage and/or the cost of the benefits that are paid under the plan. For still others, your contributions or premium payments alone provide the coverage and/or the benefits under the plan. Some of your contributions are made with pre-tax payroll deductions, and others are made with after-tax payroll deductions. See the "Cost Sharing" chart for more information.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

For Critical Illness Insurance Coverage

You pay the full premium cost of your Critical Illness Insurance coverage through after-tax deductions from your biweekly paychecks. Premiums vary based on the Critical Illness Insurance coverage option and coverage level selected, your age and your tobacco status. The premium cost of Critical Illness Insurance coverage for a calendar year is announced during the annual Open Enrollment Period that precedes that year.

For Accident Insurance Coverage

You pay the full premium cost of your Accident Insurance coverage through after-tax deductions from your biweekly paychecks. Premiums vary based on the Accident Insurance coverage option and coverage level selected. The premium cost of Accident Insurance coverage for a calendar year is announced during the annual Open Enrollment Period that precedes that year.

Cost Sharing

Cost Sharing	Benefit Plan or Program	You Pay with Pre-Tax or After-Tax Payroll Deductions
The Company Pays the Entire Cost of…	■ Coverage under the Adoption Assistance Plan ■ Coverage under the Tuition Reimbursement Program	Not applicable
You Pay the Entire Cost of…	■ Your contributions to the Family Care FSA ■ Your contributions to the CERA	You pay for your coverage or contributions through pre-tax payroll deductions.
You Pay the Entire Cost of…	■ Critical Illness Insurance ■ Accident Insurance ■ Group Legal Insurance	You pay for your coverage or contributions through after-tax payroll deductions.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Tax Implications of Making Pre-Tax Contributions

Pre-tax contributions to the Family Care FSA or the CERA reduce your taxable income and the income taxes you pay. The pre-tax contributions you make are deducted from your earnings before federal income taxes (and, in most cases, state and local income taxes) are calculated and deducted.

Pre-tax contributions also reduce the amount of Social Security taxes you pay. Because you do not pay Social Security tax on the pre-tax contributions you make, the Social Security benefits you receive in the future may be slightly reduced.

You should also know that the pre-tax (and after-tax) premiums and contributions you make for coverage do not reduce the compensation that is used to calculate your pre-tax contributions to the 401(k) Savings Plan.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Federal tax law requires that elections made when you are newly eligible or during annual Open Enrollment cannot be changed through the plan year for which they are made. Certain events in your life can affect your eligibility for benefits, and may offer you the opportunity to make changes to your coverage outside of annual Open Enrollment. Most of the life events in this section are considered exceptions and permit you to make changes upon timely notice during the 30-day period beginning on the event date and if the changes meet the consistency rule. You may be requested to provide documentation for your life event.

For detailed information about certain benefits or election options, click on the plan name to open the plan section in this Handbook. You should also review the "Eligibility and Enrollment" subsection for detailed information about who is eligible for benefits and how and when to enroll.

To make a change due to a life event, log in to the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

When Using This Section, Please Remember…
This section provides an overview of a number of life events, and does not include a comprehensive list of qualified status changes that may allow you to enroll in, change or drop coverage under UHG plans.

In addition, for purposes of this *Life Events* section, we have not included information about UHG's Reimbursement, Voluntary, and Other Benefits or policies described in this Handbook, except for the Family Care Flexible Spending Account, for which you may be able to make certain changes as the result of various qualified status changes.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

In This Section — See Page

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If Your Employment Status (Hours) Changes

Events:

- Part-time to full-time
- Full-time to part-time
- Fewer than 20 hours to more than 20 hours
- More than 20 hours to fewer than 20 hours

If you change from regular full-time employment status to regular part-time, or vice versa, you must contact HRdirect during the 30-day period beginning on the date your employment status changes if you wish to make a change to your benefits consistent with the change in employment status eligibility. See eligibility in the "Eligibility and Enrollment" subsection.

Your benefit change and biweekly paycheck deduction change become effective on the first of the month following the date of your employment status change. Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

You will have the opportunity to make changes each year during the annual Open Enrollment Period, or following an applicable qualified life event.

The following table outlines how your benefits coverage is affected when your employment status changes.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	■ Coverage and contribution levels are not affected.	If your need for day care changes, you may change your contribution consistent with the change in your status/hours.
Critical Illness Insurance	*Coverage is not affected by this event.* ■ You may not change your plan option. ■ You are not permitted to add, increase, decrease or cancel coverage.	
Accident Insurance	*Coverage is not affected by this event.* ■ You may not change your plan option. ■ You are not permitted to add, increase, decrease or cancel coverage.	
Group Legal Insurance	*No change is permitted for this event.*	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If You Get Married or Establish a Domestic Partnership

Events:

- Marriage
- Establish a domestic partnership

You must go online or contact HRdirect during the 30-day period beginning on the date of your marriage (or the date you first satisfy the domestic partner criteria) if you wish to make a change to your benefits and the change is consistent with the marriage or domestic partner relationship. After that, you will have the opportunity to make changes each year during the annual Open Enrollment Period, or following an applicable qualified life event.

Your benefit change and biweekly paycheck deduction change become effective on the first of the month following your date of marriage (or the date you first satisfy the domestic partner criteria). Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

The following table outlines how your coverage is affected if you get married or attain domestic partnership status:

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	*You can:* ■ Add or increase contributions if your new dependents will have eligible expenses. ■ Decrease or cancel contributions if you certify that your spouse/domestic partner does not work outside the home.	Expenses for dependent children age 13 or older are not eligible for reimbursement unless the children are otherwise considered qualified dependents. *See the definitions for Family Care FSA/ Dependent Care Reimbursement Account (DCRA) Dependent Child or Family Care FSA/ Dependent Care Reimbursement Account (DCRA) Dependent, and eligible dependent care expenses in the "Glossary" section.* For their expenses to be eligible for reimbursement, domestic partners and their child(ren) must be federal tax dependents.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Critical Illness Insurance	*You can:* ■ Enroll yourself and/or your new spouse/domestic partner and/or any newly eligible dependent child. ■ Cancel coverage.	
Accident Insurance	*You can:* ■ Enroll yourself and/or your new spouse/domestic partner and/or any newly eligible dependent child. ■ Cancel coverage.	
Group Legal Insurance	■ You can enroll or cancel coverage.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If You Gain a Dependent Child

Events:

- Birth, adoption or placement for adoption

If you wish to make a change to your benefits consistent with the gain of a dependent child, you must go online or contact HRdirect during the 60-day period beginning on the date of the birth, adoption or placement for adoption. You must take steps to add a new dependent child even if you already have other dependent coverage in effect. After that, you will have the opportunity to make changes each year during the annual Open Enrollment Period, or following an applicable qualified life event.

Your benefit change becomes effective on the date of the dependent child's birth, adoption or placement for adoption. Your biweekly paycheck deduction change, if applicable, becomes effective on the first paycheck following the date of the dependent child's birth, adoption or placement for adoption. Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

If you are adopting a child and you work at least 20 hours per week, the Company offers the Adoption Assistance Plan, as described in this Handbook.

The following table outlines how your coverage is affected when you gain a dependent child.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	*You can:* ■ Elect or increase contributions if your new dependents will have eligible expenses. *You cannot decrease or cancel contributions.*	Expenses for dependent children age 13 or older are not eligible for reimbursement unless the children are otherwise considered qualified dependents. *See the definitions for Family Care FSA/ Dependent Care Reimbursement Account (DCRA) Dependent Child or Family Care FSA/ Dependent Care Reimbursement Account (DCRA) Dependent, and eligible dependent care expenses in the "Glossary" section.* For their expenses to be eligible for reimbursement, domestic partners and their child(ren) must be federal tax dependents.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Critical Illness Insurance	*You can:* ■ Enroll yourself and/or your new dependent child and/or any newly eligible dependents. ■ Decrease or cancel coverage.	
Accident Insurance	*You can:* ■ Enroll yourself and/or your new dependent child and/or any newly eligible dependents. ■ Decrease or cancel coverage.	
Group Legal Insurance	■ You can enroll or cancel coverage.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If You Divorce or Your Domestic Partnership Ends

Events:

- Divorce, legal separation, annulment or end of domestic partnership

You must contact HRdirect during the 60-day period beginning on the date of your divorce, legal separation or annulment (including ending domestic partnership) if you wish to make a change to your benefits consistent with the divorce, legal separation or annulment or the end of domestic partnership. See "Election Changes Deadline and Effective Date" regarding ineligible dependents.

If you notify HRdirect within 60 days, your benefit change and biweekly paycheck deduction change become effective on the first of the month following your date of divorce, legal separation or annulment, or the date your domestic partnership terminates. Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

The following table outlines how your benefits coverage is affected when you end your marriage or domestic partnership.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	*You can:* ■ Add or increase contributions if you certify that, as a result of divorce, legal separation or annulment, you have new or additional expenses for eligible dependent(s). ■ Decrease contributions or cancel contributions if you certify that your dependent(s) with eligible expenses will reside with your spouse/domestic partner and your dependent care needs are reduced or eliminated.	If you add coverage, any expenses incurred before your benefits effective date are not eligible for reimbursement.
Critical Illness Insurance	*You can:* ■ Add or increase coverage for yourself and your eligible dependent child(ren), if you are not already covered by the plan. ■ Decrease coverage to drop your spouse/domestic partner or dependent child.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Accident Insurance	*You can:* ■ Add or increase coverage for yourself and your eligible dependent child(ren), if you are not already covered by the plan. ■ Decrease coverage to drop your spouse/domestic partner or dependent child.	
Group Legal Insurance	■ You can enroll or cancel coverage.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If You or Your Spouse/Domestic Partner or Dependent Gains/ Loses Coverage under Another Group Plan

Events:

- Gain eligibility under another group plan
- Lose eligibility under another group plan
- Lose premium subsidy under another group plan

You must contact HRdirect during the 30-day period beginning on the date the other coverage began or ended if you wish to make a change to your benefits consistent with your or your spouse's/domestic partner's or dependent's gain or loss of coverage under another employer's group plan. This includes a loss of employer premium subsidy for coverage under another employer's group plan.

Your benefit change and biweekly paycheck deduction change become effective on the first of the month following the beginning or end of the other coverage. Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

You will have the opportunity to make changes each year during the annual Open Enrollment Period, or following an applicable qualified life event.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

The following table outlines how your benefits coverage is affected when coverage under another group plan is involved.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	*If your dependent gains coverage:* ■ You can decrease or cancel contributions if you certify that you and/or your eligible dependents gained coverage under your spouse's dependent care reimbursement account. ■ You are not permitted to add or increase coverage for this event. *If your dependent loses coverage:* ■ You can add or increase contributions if you certify that you and/or your eligible dependents lost coverage under your spouse's dependent care reimbursement account plan. ■ You are not permitted to decrease or cancel coverage for this event.	If you add coverage or increase contributions, any expenses incurred before your benefits effective date are not eligible for reimbursement. Domestic partners and their child(ren) are not eligible to participate in your Family Care FSA unless they meet the definitions for "Eligible Family Care FSA Dependent" and "Family Care FSA/Dependent Care Reimbursement Account (DCRA) Dependent Child" in the "Glossary" section.
Critical Illness Insurance	*If your dependent gains coverage:* ■ You can decrease or cancel coverage. *If your dependent loses coverage:* ■ You can add or increase coverage.	
Accident Insurance	*If your dependent gains coverage:* ■ You can decrease or cancel coverage. *If your dependent loses coverage:* ■ You can add or increase coverage.	
Group Legal Insurance	*If you gain or lose eligibility for another employer's plan, no change is permitted for this event.* *If your spouse/domestic partner loses coverage:* ■ You can enroll. *If your spouse/domestic partner gains coverage:* ■ You can cancel coverage.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If Your Spouse's/Domestic Partner's Employer's Plan Changes

If your spouse/domestic partner changes coverage under his or her employer's plan, you can make certain prospective changes to your coverage as shown in the table below if the following conditions are met:

- The changes to your coverage are due to, and correspond with, a permitted change made under your spouse's/domestic partner's employer's group health plan (for example, if your spouse's/domestic partner's employer removes or decreases a benefit or adds a new benefit option midyear and your spouse/domestic partner can and does elect coverage under the new option); or
- Your spouse/domestic partner elects coverage under his or her employer's group plan during that plan's annual enrollment period, if the annual enrollment period is different from the Company's annual Open Enrollment Period.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	*You can:* ■ Add or increase contributions if you are dropping coverage under your spouse's/domestic partner's dependent care reimbursement account plan. ■ Cancel or decrease contributions if you and/or any dependent(s) certify that coverage has been elected under your spouse's/domestic partner's employer's dependent care reimbursement account plan.	
Critical Illness Insurance	*Coverage is not affected by this event.* ■ You may not change your plan option. ■ You are not permitted to add, increase, decrease or cancel coverage.	
Accident Insurance	*Coverage is not affected by this event.* ■ You may not change your plan option. ■ You are not permitted to add, increase, decrease or cancel coverage.	
Group Legal Insurance	■ You can enroll or cancel coverage.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If Your Dependent Child Loses Eligibility for Coverage

Events:

- Child turns age 26

Unless he or she is disabled, if your dependent child turns age 26, you must go online or contact HRdirect during the 60-day period beginning on the date eligibility is lost if you wish to make a change to your benefits consistent with the change in your dependent's eligibility for coverage. See "Election Changes Deadline and Effective Date" regarding ineligible dependents.

If you notify HRdirect within 60 days, your benefit change and biweekly paycheck deduction change become effective on the first of the month following the date of loss of eligibility. Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

Note: If your dependent is disabled prior to age 26, you must complete the "Statement of Dependent Eligibility beyond Limiting Age Due to Mental or Physical Disability" form no later than 60 days after any of the following: the date the child would otherwise lose coverage under the plan, your hire or acquired date, or the loss of other group insurance.

The following table outlines how your benefits coverage is affected when your dependent's eligibility changes.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Critical Illness Insurance	*You can:* ■ Drop coverage only for the dependent losing eligibility. ■ You are not permitted to add any other dependents or cancel coverage.	
Accident Insurance	*You can:* ■ Drop coverage only for the dependent losing eligibility. ■ You are not permitted to add any other dependents or cancel coverage.	
Group Legal Insurance	■ No change is permitted for this event.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If Your Dependent Turns Age 13 and You Participate in the Family Care FSA

Events:

- Child turns age 13

Unless he or she is disabled, if your dependent child turns age 13, you must go online or contact HRdirect during the 60-day period beginning on the date eligibility is lost if you wish to make a change to your benefits consistent with the change in your dependent's eligibility for coverage. See "Election Changes Deadline and Effective Date" regarding ineligible dependents.

If you notify HRdirect within 60 days, your benefit change and biweekly paycheck deduction change become effective on the first of the month following the date of loss of eligibility. Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

The following table outlines how your benefits coverage is affected when your dependent's eligibility changes.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	*If your dependent loses eligibility:* ■ You can decrease your contributions only relating to the decrease of expenses for the dependent losing eligibility. ▫ You may decrease contributions only to the amount you contributed before your dependent lost eligibility ■ You are not permitted to enroll in, increase or cancel contributions for this event.	Determine whether you need to change your contribution rate. Expenses for a minor child(ren) age 13 or older are not eligible for reimbursement, unless the child is otherwise considered a qualified dependent (see the "Glossary" section for the definition of qualified dependent). Contact HRdirect to remove from your coverage a dependent who turns age 13.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If You Move to a New Resident Address

Moving is considered a qualified status change or life event, meaning that you can make certain adjustments to your benefits if the change is consistent with the move. If you don't enroll or make changes to certain benefits during the 30-day period beginning on your move date, you must wait until the next Open Enrollment Period or until you have another life event to enroll or make changes.

When you move, remember to update your address on Global Self Service (GSS). If you move out of state, you must complete a new IRS Form W-4, where applicable.

The following table outlines how your coverage is affected if you move.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	■ You can increase or decrease your contributions if you certify that, as a result of your move, your dependent day care needs or the cost of the day care has changed. ■ You cannot cancel your contributions as a result of this event.	Consider costs of the day care, your work hours or your need for less or more day care, or if the day care provider changed as a result of the residence change.
Critical Illness Insurance	*Coverage is not affected by this event.* ■ You may not change your plan option. ■ You are not permitted to add, increase, decrease or cancel coverage.	
Accident Insurance	*Coverage is not affected by this event.* ■ You may not change your plan option. ■ You are not permitted to add, increase, decrease or cancel coverage.	
Group Legal Insurance	■ No change is permitted for this event.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If Your Cost or Need for Day Care Changes

As long as the day care provider is not your relative, you may increase or decrease contributions if your dependent care costs or coverage needs change. For example, if your dependent's day care center increases its rates, you can increase your contributions prospectively, as long as you have not already elected to contribute the annual maximum. Similarly, if your work hours change and you need less (or more) hours of day care, you can make a corresponding change to your election. If you don't enroll or make changes to your Family Care FSA election within 30 days from the date the change in cost or need occurred, you must wait until the next Open Enrollment Period or until you have another eligible life event to enroll or make changes.

The following table outlines how your coverage is affected if the cost of day care or need for day care changes.

Benefit Plan	What Happens to Your Coverage	Things to Consider
Family Care FSA	■ You can increase or decrease your contributions if you certify that your dependent day care needs or the cost of the day care has changed. ■ You cannot cancel your contributions as a result of this event. You may only decrease your contribution down to the amount you have contributed prior to the event.	Consider costs of the day care, your work hours or your need for less or more day care, or if the day care provider changed.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If You or Your Dependents Gain/Lose Eligibility for Medicaid/Medicare

Events:

- Dependent gains coverage
- Dependent loses coverage

Contact HRdirect during the 60-day period beginning on the date of change in Medicare eligibility, or the date of change in Medicaid eligibility, if you wish to make a change to your benefits consistent with the change in eligibility. Your benefit change and any change in biweekly payroll deductions become effective on the first of the month following the date of eligibility.

Any retroactive benefit premiums will be adjusted as applicable on your first available biweekly paycheck for any previous paycheck dates that occurred on or after your benefits effective date.

The following table outlines how benefits coverage is affected by a change in eligibility for Medicaid/Medicare.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	■ You are not permitted to change your contributions.	Not applicable
Critical Illness Insurance	*If you or your dependents gain eligibility:* ■ You can decrease or drop coverage for you and your dependents. *If you or your dependents lose eligibility:* ■ You can enroll/increase coverage for you and your dependents.	
Accident Insurance	*If you or your dependents gain eligibility:* ■ You can decrease or drop coverage for you and your dependents. *If you or your dependents lose eligibility:* ■ You can enroll/increase coverage for you and your dependents.	
Group Legal Insurance	■ No change is permitted for this event.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If Death Occurs While You Are Actively Employed

Event:

- Death of employee

If you die while employed by a participating employer, benefit termination processing is automatic based on the date of your death.

Your biweekly paycheck deduction(s) will continue through your last paycheck of the month of your death. A COBRA enrollment notice will be mailed to your impacted eligible covered dependent(s) and will contain information applicable to dependent coverage at your death.

You are responsible for making sure that your beneficiary designation is up to date and that information on your beneficiaries is current.

The following table outlines how coverage is affected if you die. At the end of the table, there is information on how coverage is affected if your spouse or child dies.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	■ Coverage for your dependent(s) continues until the last day of the month following your death. ■ Your spouse may continue to incur eligible expenses until the end of the calendar year of your death and receive reimbursement up to the cash balance in the Family Care FSA account. ■ No COBRA rights are available for this benefit.	Your spouse may continue to incur eligible expenses until the end of the calendar year of your death. Your spouse may submit eligible claims until April 30 of the following calendar year.
Critical Illness Insurance	■ If applicable, coverage for your spouse/domestic partner and dependent child(ren) continues until the last day of the month following your death. ■ No COBRA rights are available for this benefit.	
Accident Insurance	■ If applicable, coverage for your spouse/domestic partner and dependent child(ren) continues until the last day of the month following your death. ■ No COBRA rights are available for this benefit.	
Group Legal Insurance	■ No COBRA rights are available for this benefit.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

If an Eligible Dependent's Death Occurs

Events:

- Death of spouse
- Death of domestic partner
- Death of child

If your spouse/domestic partner or dependent child dies while you are employed by a participating employer, your benefit coverage may be impacted. Coverage for the dependent ends on the date of your dependent's death. The following table outlines how coverage is affected if your spouse/domestic partner or dependent child dies. You can make changes if the changes are consistent with the loss of your spouse/domestic partner or dependent child.

Benefit Plans	What Happens to Your Coverage	Things to Consider
Family Care FSA	■ You can reduce contributions, provided you certify that you have reduced expenses as a result of your spouse's/domestic partner's or dependent child's death. ■ If your spouse/domestic partner dies, you can increase contributions if you certify that you have additional eligible expenses as a result of your spouse's/domestic partner's death.	
Critical Illness Insurance	■ You can drop your deceased dependent (spouse/domestic partner or dependent child) from your coverage.	
Accident Insurance	■ You can drop your deceased dependent (spouse/domestic partner or dependent child) from your coverage.	
Group Legal Insurance	■ You can enroll or cancel coverage.	

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UnitedHealth Group Incorporated (UHG or the Company) sponsors the UnitedHealth Group Family Care Flexible Spending Account (the Family Care FSA), which is a benefit plan under the UHG Inc. Group Benefits Plan. The Family Care FSA has a dependent care assistance plan (DCAP) component as that term is described in Internal Revenue Code Section 129. The Family Care FSA is not subject to ERISA and is not required to be summarized in a Summary Plan Description (SPD). Even though it is not subject to the SPD requirement, we have prepared this *Family Care FSA* section, which in combination with the "Introduction" section, the "Eligibility and Enrollment" section, the "Administrative Information" section, and applicable defined terms in the "Glossary" section, summarizes the Plan.

Questions?

If you have questions about your Family Care Flexible Spending Account benefits, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

In This Handbook **See Page**

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the Family Care FSA Works

The Family Care FSA lets you put money aside from your biweekly paycheck pre-tax to pay for certain eligible dependent care expenses for your eligible Family Care FSA dependents when the expenses are incurred so you can work. You choose how much you'll contribute to your account through biweekly payroll deductions.

UnitedHealthcare Insurance Company, a member of the UnitedHealth Group family of companies, through its UnitedHealthcare Flexible Spending Account Unit, administers the Family Care FSA benefit reimbursements.

The Family Care FSA also offers resources, discounts and support services for child care and elder care.

The following table provides an overview of the Family Care FSA and its features.

Key Features	■ The Family Care FSA reimburses you for eligible dependent care expenses for the care of your eligible Family Care FSA dependents when the expenses are incurred so you can work. ■ Minimum contribution: $200 per year. ■ Maximum contribution: $5,000 per year if single or married, filing a joint income tax return ($2,500 if married, filing a separate income tax return). ■ Tax savings: Contributions are pre-tax, and qualified reimbursements are tax-free. ■ You decide how much you want to contribute to your reimbursement account each year, not to exceed $5,000. Then, you can use the money in your account to reimburse yourself for eligible dependent care expenses incurred during the current calendar year and up to March 15 (the grace period extension) of the following calendar year. ■ For details, visit myuhc.com.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Eligible Expenses	Use your account to reimburse yourself for eligible expenses, including: ■ Child care expenses for children **under age 13**: ▫ Babysitter (care in your home or someone else's) ▫ Before- and after-school programs, including extended care programs ▫ Child care ▫ Nursery school ▫ Preschool ▫ Summer day camp ■ Elder care expenses: ▫ Adult day care center ▫ Elder care (care in your home or someone else's) ■ Expenses for care of a mentally or physically incapacitated spouse or dependent.
Forfeit of Funds	Be sure to estimate your contributions carefully. Contribute only the amount of money you expect to use. Federal law requires that if you do not use your entire Family Care FSA balance for a given plan year's expenses (including the grace period extension), you will forfeit any unused money in your account.
Highly Compensated Employee (HCE)	If you earned more than $130,000 in 2020, you are considered a Highly Compensated Employee (HCE) in 2021 per IRS guidelines for flexible spending accounts. If the Plan does not meet IRS thresholds for participation, the Family Care FSA requires contributions to be reduced only for HCEs in order to preserve the tax-favored status of the Plan. The amount of the reduction for HCEs, if any, will vary from year to year based on participation rates in the Plan. If your spouse is eligible to contribute to a dependent care reimbursement account through his or her employer, you may want to consider using your spouse's plan for some or all of your family's contribution to avoid a reduction under the Family Care FSA.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Resources	Through the Employee Assistance Program, access a variety of child care and elder care referrals and resources. Call 866-781-6396 for 24/7 assistance. ■ Available to exempt, non-exempt, full-time and part-time employees. ■ Through Solutions for Caregivers, you have access to free and reduced rate services to help you face the challenges and difficult decisions of caring for a parent or aging family member, including: ▫ Comprehensive onsite assessment ▫ Personalized short- and long-term care plans ▫ Identification of community resources and services and payer (e.g., Medicare) for each service ▫ Facilitation and coordination of services ▫ Monitoring ongoing needs and care plans for your relative ■ The Company pays 100% of: ▫ Cost of one comprehensive in-house assessment each year ▫ Up to six hours of hourly case management services for an aging family member For more information: ■ Call 866-781-6396 (select Employee Assistance Program from the main menu). ■ Visit the LiveandWorkWell website. ■ Access code: united
Bright Horizons Enhanced Family Supports™	Helps you find sitters, nannies, housekeepers, pet care (including pet sitters and dog walkers), child care support, test prep and tutoring. Visit https://clients.brighthorizons.com/unitedhealthgroup and follow the instructions to activate your membership and search the database.
Bright Horizons Back-Up Care™	Offers center- and home-based care, subsidized by UnitedHealth Group, to use when your regular care arrangements fall through or are unavailable and your job requires you to be at work. Visit https://clients.brighthorizons.com/unitedhealthgroup to register and make reservations for care.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Pre-Tax Contributions

Tax Savings Example

Here's an example of how your Family Care FSA contributions can help you save money. This example assumes you are married and have two children, your combined gross annual income is $50,000 and you contribute $1,500 to the Family Care FSA.

	With Family Care FSA Contributions	Without Family Care FSA Contributions
Combined Gross Annual Income	$50,000	$50,000
Pre-Tax Contributions	- $1,500	- $0
Taxable Income (W-2 pay)	$48,500	$50,000
*Estimated Federal/FICA Taxes**	- $14,380.25	- $14,825
After-Tax Income	$34,119.75	$35,175
Tax Savings	**$1,055.25**	**$0**

* Estimates are based on 2021 tax tables using federal supplemental tax, Social Security and Medicare rates. State taxes have not been included but could represent additional savings if you would have otherwise paid state tax on the money you contribute to your account. The actual amount you save in taxes will depend on your personal situation.

Effect on Taxes

Under current IRS rules, you may be able to claim a tax credit for eligible dependent care expenses when you file your federal income tax return. If you receive reimbursement from the Family Care FSA for your eligible dependent care expenses, you can't claim a federal dependent care tax credit for the same expense. In fact, the amount of any expenses reimbursed under the Family Care FSA reduces, dollar-for-dollar, the amount of eligible dependent care expenses that the IRS allows you to claim for a federal tax credit. Dependent care expenses may also qualify for a tax credit on some state income tax returns. Your eligibility for the federal and/or state credit and the amount of the credit is based on your adjusted gross income and number of qualified dependents.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

You should consider which method — the Family Care FSA or the tax credit — offers you the greatest tax savings. Before you decide whether to claim a federal dependent care tax credit or contribute to the Family Care FSA, you are encouraged to consult with a qualified tax specialist.

Use It or Lose It

Be sure to estimate your contributions carefully. Contribute only the amount of money you expect to use. Federal law requires that if you do not use your entire Family Care FSA balance for a given Plan year's expenses (including the grace period extension), you will forfeit any unused money in your account.

This means that you must use all of the money in your account, or you will lose it. The money in your account cannot be returned to you, be carried over to the next calendar year for next year's expenses or be transferred to another account, such as your Health Care Flexible Spending Account (Health Care FSA). Generally, you should elect to make contributions for only those eligible dependent care expenses that you know you will incur during the coverage period.

When Contributions End

Your contributions under the Family Care FSA automatically end on the date which the earliest of the following occurs:

- Your employment with the Company ends for any reason;
- You fail to pay required contributions when they are due; or
- You cease to be eligible to participate in the Family Care FSA.
- Your contributions will be discontinued while you are on leave and will resume when you return to work within the same year. If you return to work the following calendar year, you must call HRdirect at 800-561-0861, to re-enroll even if you elected this plan during Open Enrollment.

When Benefits Are Paid

The Family Care FSA pays reimbursement benefits only for eligible dependent care expenses that are:

- Listed in the "Eligible Dependent Care Expenses" subsection;
- Provided while the eligible Family Care FSA dependent who receives the services is eligible for reimbursement benefits under the Family Care FSA; and
- Obtained in accordance with the Family Care FSA's terms.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Your Family Care FSA Coverage

This section provides additional information, such as how much you can contribute to this account, any limits that may apply, and expenses that are and are not eligible for reimbursement.

Contribution Levels

Prior to enrolling in the Family Care FSA, you decide how much to contribute to your account through pre-tax payroll deductions. You may elect to make no contribution or to contribute a minimum of $200 up to a maximum of $5,000 to the Family Care FSA per calendar year. Your contributions will be deducted in equal amounts from each biweekly paycheck you receive during that calendar year.

- Minimum contribution: $200 per year.
- Maximum contribution: $5,000 per year if single or married, filing a joint income tax return ($2,500 if married, filing a separate income tax return).
- Tax savings: Contributions are pre-tax, and qualified reimbursements are tax-free.
- You decide how much you want to contribute to your reimbursement account each year, not to exceed $5,000. Then, you can use the money in your account to reimburse yourself for eligible dependent care expenses incurred during the current calendar year and up to March 15 (the grace period extension) of the following calendar year.
- For details, visit myuhc.com.

Keep in mind that you are reimbursed only for eligible dependent care expenses that you incur during a given plan year (including the grace period extension). But you have until April 30 of the following calendar year to submit eligible dependent care expenses for reimbursement.

Special rules apply if you live in a location with access to the Backup Child Care Program, and you use that program. Read the "Use of Back-Up Child Care Program" subsection for information.

If your spouse is enrolled in a dependent care reimbursement account with another employer, you and your spouse may only collectively elect to contribute up to the $5,000 maximum. Refer to the "Your Annual Contribution Limit" subsection.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Estimating Your Contributions

To estimate your eligible dependent care expenses for the plan year, consider how much you currently pay for dependent care that is provided by:

- A day care center;
- An elder/dependent care facility, as long as the facility is not a nursing home;
- A housekeeper, maid or cook, as long as he or she is responsible for the wellbeing and protection of an eligible Family Care FSA dependent (including meal and lodging expenses);
- A babysitter or companion, including your children age 19 or over and relatives whom you cannot claim as exemptions on your federal tax return;
- A nursery school or preschool; or
- A day camp.

You can only claim eligible dependent care expenses for services that allow:

- You and your spouse to work or look for work;
- You to work and your spouse to attend school full-time for at least five months during the year; or
- You to work while your spouse is mentally or physically disabled and in need of care, or is unable to provide care.

If care is provided at a day care or elder/dependent care center, to be eligible, the center must comply with all state and local regulations that apply to these centers. A center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, even if the center is not run for profit.

Your work and that of your spouse may be done for others or in your own business. This includes work that is either full-time or part-time; however, it doesn't include volunteer work.

Note: You may not be reimbursed for care expenses incurred while you are off work because of illness or leave of absence.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Your Annual Contribution Limit

When you enroll in the Family Care FSA, certain IRS rules may affect the amount you can contribute.

If This Is Your Situation…	Then Your Maximum Annual Family Care FSA Contribution Is…
You Are Single	$5,000 or your earned income, whichever is less.
You Are Married ■ Both you and your spouse earn more than $5,000 per year; and ■ You file a combined income tax return.	A combined total of $5,000. If you and your spouse both have access to dependent care reimbursement accounts, the $5,000 total can be contributed to one of the accounts or split between the two accounts. For example, if your spouse deposits $1,000 in his or her dependent care reimbursement account, the maximum you can set aside in the Family Care FSA is $4,000.
You Are Married ■ Both you and your spouse earn more than $5,000 per year; and ■ You and your spouse file separate income tax returns.	$2,500 under the Family Care FSA, plus $2,500 under your spouse's dependent care reimbursement account.
You Are Married ■ Either you or your spouse earns less than $5,000 per year.	The amount that the lower-paid spouse earns.

If you are married, you and your spouse must be working or your spouse must be seeking full-time employment, be a full-time student or be physically disabled in order to participate in the Family Care FSA. To qualify as a full-time student, your spouse must be enrolled at and attend school on a full-time basis for some part of five calendar months during the year. You may not contribute to the Family Care FSA during any period in which your spouse does not have earned income. If your spouse is seeking full-time employment, is a full-time student or is physically disabled, your spouse is deemed to have earned income of $250 a month (if you have one eligible Family Care FSA dependent) or $500 per month (if you have two or more eligible Family Care FSA dependents).

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Limits for Higher-Paid Employees

Family Care FSA contributions may be limited for higher-paid employees, as required by law, depending on the mix of employee participation. If you are affected, you will be notified, and your contribution will be adjusted. If you earned more than $130,000 in 2020, you are considered a Highly Compensated Employee (HCE) per IRS guidelines for flexible spending accounts in 2021. If the Plan does not meet IRS thresholds for participation, the Family Care FSA requires contributions to be reduced only for HCEs in order to preserve the tax-favored status of the plan. The amount of the reduction for HCEs, if any, will vary from year to year based on participation rates in the plan.

Consider taking the following actions to reduce your risk of a midyear reduction in your contributions:

- Enroll in a spouse's Dependent Care Spending Account for some or all of the combined $5,000 maximum.
- Consult with your tax advisor regarding your various options with the Family Care FSA and the Dependent Care Tax Credit.

Use of Back-Up Child Care Program

If you use the Bright Horizons Back-Up Care, the Company's contribution toward the cost of your child's use of the Bright Horizons Back-Up Care will count toward the Family Care FSA $5,000 contribution maximum. Visit "Bright Horizons Back-Up Care" on the Benefits Site at https://benefitsenroll.uhg.com for more information.

Eligible Family Care FSA Dependents

You may only request reimbursement from the Family Care FSA for eligible dependent care expenses that you pay for your eligible Family Care FSA dependents. As an eligible employee, your eligible Family Care FSA dependents include:

- A child who is your Family Care FSA dependent child, who lives with you for more than one-half of the year;
- Your spouse:
  - Who is physically or mentally unable to care for himself or herself;
  - Who lives with you for more than one-half of the year;
  - Who regularly spends at least eight hours a day in your household; and
- Any other person:
  - For whom you provide support for more than one-half of the year;
  - Who is a member of your household;
  - Who is physically or mentally unable to care for himself or herself; and
  - Who lives with you for more than one-half of the year.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Eligible Dependent Care Expenses

The Family Care FSA reimburses you for eligible dependent care expenses incurred so that you and your spouse can work. You can only receive reimbursement for those eligible dependent care expenses that are incurred (not necessarily billed) during a given plan year (including the grace period extension) in which you participated in the Family Care FSA. You cannot use your Family Care FSA contributions to pay for services you incurred before your participation began or after your participation ends for that plan year.

In order for you to submit a claim for reimbursement, your dependent care provider must have a tax identification or Social Security number. The claims administrator has the complete discretion as to whether or not an expense is reimbursable and has the authority to request additional information to substantiate your claim for reimbursement.

The following list of eligible dependent care expenses is not intended to be comprehensive. It provides examples of dependent care expenses that the IRS considers eligible for reimbursement from the Family Care FSA.

Examples of expenses that usually or generally are eligible for reimbursement include but are not limited to payments for:

- A day care center or nursery school that is licensed and complies with all state and local regulations, provides care for more than six nonresidents and receives a fee for such services, whether or not for profit;
- A housekeeper, maid or cook, as long as his or her duties include care of an eligible Family Care FSA dependent (including meal and lodging expenses);
- Preschool tuition;
- Before- and after-school programs;
- Day camp (including specialty camps), only if the camp qualifies as a day care center within your state and the primary purpose is the care of your eligible Family Care FSA dependent;
- Babysitters or companions, including your eligible dependents age 19 or over and relatives whom you cannot claim as exemptions on your federal tax return;
- An elder or dependent care facility;

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- A person who cares for an elderly or disabled eligible Family Care FSA dependent in your home;
- Meals and lodging provided to your caregiver, including additional rent and utilities as well as food; and
- Social Security Tax (FICA), Federal Unemployment Tax (FUTA) and similar state taxes that you pay on behalf of the person caring for an eligible Family Care FSA dependent.

Dependent Care Expenses Not Eligible for Reimbursement

The following list of ineligible expenses is not intended to be comprehensive. It provides examples of dependent care expenses that the IRS considers not eligible for reimbursement from the Family Care FSA.

Examples of expenses that usually or generally are not eligible for reimbursement include but are not limited to payments for:

- Expenses incurred before your date of participation in the Family Care FSA or after the plan year (including the grace period extension) ended;
- Amounts you pay for dependent care while you are off work because of illness or leave of absence;
- Dependent care paid to an individual who could be claimed as a dependent on your (or your spouse's) tax return;
- Dependent care paid to your eligible dependent who is under age 19 at the end of the taxable year;
- Finder's fees for placement of an au pair or nanny;
- Dependent care that is provided for reasons that are not work-related;
- Expenses for transportation between your home and the place where care is provided;
- Overnight camp and school tuition expenses for an eligible Family Care FSA dependent in the first grade and up;
- Expenses you deduct or for which you take a dependent care tax credit on your federal income tax return;
- Care received in a nursing home;
- Dependent care expenses that enable your spouse to do volunteer work; and
- Food or clothing expenses (except for small amounts paid for these items that cannot be separated from the cost of dependent care).

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Other Information

This section includes important information about filing Family Care FSA claims for reimbursement.

Filing a Claim for Reimbursement

To receive reimbursement from the Family Care FSA, you must file a claim. You may be reimbursed for eligible dependent care expenses up to the amount of your contributions that have been deducted as of the date of your claim. Family Care FSA reimbursement claims are processed daily. Your reimbursement request generally must be for at least $25 in eligible dependent care expenses.

How to Obtain a Claim Form

You can obtain a "Request for Reimbursement for Dependent Care Expenses for the UnitedHealth Group Family Care FSA" form for reimbursement from the Family Care FSA by:

- Accessing myuhc.com; or
- Calling Health Care Advisor at 800-357-1371.

How to File a Claim

You have a couple of options available to you when filing a claim for reimbursement. You can file:

- Your claim on myuhc.com.
- A paper claim by printing out a claim form from myuhc.com.

When filing a claim for reimbursement, you must provide evidence that clearly identifies the eligible dependent care expenses you have incurred and shows that they were provided for an eligible Family Care FSA dependent. Your claim must include:

- A completed "Request for Reimbursement for Dependent Care Expenses for the UnitedHealth Group Family Care FSA" form (paper or online version);
- The name, address and Social Security or tax identification number of your dependent care provider;
- The nature of the dependent care services provided;
- The names of the eligible Family Care FSA dependents who received care; and
- The date dependent care services were provided and the amount of the charges.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

You should send your completed "Request for Reimbursement for Dependent Care Expenses for the UnitedHealth Group Family Care FSA" and required documentation to the following address:

UnitedHealthcare
P.O. Box 981506
El Paso, Texas 79998-1506
Fax: 915-231-1709
Toll-free fax: 866-262-6354

Annual Submission Deadline

You have until April 30 of the following calendar year to submit reimbursement claims incurred during the year of participation, which includes the grace period extension.

This deadline applies even if you do not continue to make contributions to the Family Care FSA for the entire year. If your contributions end, you may be reimbursed for eligible dependent care expenses incurred for eligible Family Care FSA dependents through the end of the plan year (including the grace period extension) in which your coverage ended, as long as you have unused amounts in your Family Care FSA account.

All claims for reimbursement of eligible dependent care expenses must be postmarked by the April 30 submission deadline. Remember that any money remaining in your account after the submission deadline and for which no timely reimbursement claim has been made will be forfeited as of May 1.

Grace Period Extension

If you are covered under and contributing to the Family Care FSA as of the last day of the calendar year and have money left over in your Family Care FSA on that date, you can continue to incur eligible dependent care expenses during the grace period extension (i.e., up to March 15 of the next calendar year) and receive reimbursement from amounts remaining at the end of the prior calendar year.

Note: Terminated employees can no longer contribute to the Family Care FSA; therefore, the grace period extension does not apply, and they can only submit claims for services received during the calendar year in which they terminated, provided they have funds remaining in their account.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How You'll Receive Your Reimbursement

Family Care FSA reimbursement claims are processed daily. Your reimbursement payment will be mailed to your home address within seven to 10 business days after receipt of your completed "Request for Reimbursement for Dependent Care Expenses for the UnitedHealth Group Family Care FSA" form and documentation. Your reimbursements will be paid with pre-tax dollars. These amounts will not be reported as taxable income on your IRS Form W-2.

You can choose to receive your reimbursement payments via direct deposit into the checking or savings account of your choice. To elect this feature, go to myuhc.com.

An Explanation of Benefits (EOB) will be sent with each reimbursement check. It will list the amounts reimbursed and your remaining account balance. Each year, in October, a statement will be mailed to you indicating your remaining account balance and reminding you that you must use your account for eligible dependent care expenses before the end of the calendar year or lose the remaining account balance. You may also view and print quarterly EOB information online by accessing myuhc.com.

How to Check on the Status of a Claim

You may check on the status of a reimbursement claim by:

- Accessing myuhc.com; or
- Calling Health Care Advisor at 800-357-1371.

If you access myuhc.com, you can:

- Review your Family Care FSA balance and summary information;
- View your EOBs and see up to the most recent 18 months of history;
- See examples of eligible and ineligible dependent care expenses; and
- Submit a Family Care FSA claim online.

You can use myuhc.com to review your Family Care FSA activity even if you do not participate in the Medical Plan.

If Your Claim Is Denied

If you are informed that your claim for reimbursement has been denied, you have the right to appeal that decision. Your rights are explained in the "Claims for Benefits Under Certain Non-ERISA Plans" subsection.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UnitedHealth Group Incorporated (the Company) sponsors the Commuter Expense Reimbursement Account (the CERA), which is a benefit plan under the UHG Inc. Group Benefits Plan. The CERA is not subject to ERISA and is not required to be summarized in a Summary Plan Description (SPD). Even though it is not subject to the SPD requirement, we have prepared this *Commuter Expense Reimbursement Account* section, which in combination with the "Introduction" section, the "Eligibility and Enrollment" section, the "Administrative Information" section, and applicable defined terms in the "Glossary" section, summarizes the plan.

Questions?

If you have questions about the CERA benefit features, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861. If you have questions about your account, call HealthEquity at 877-311-7849.

In This Section **See Page**

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the CERA Works

The CERA lets you put money aside from your paycheck pre-tax to pay for certain eligible commuter expenses that you incur during the year for transportation to and from your place of employment with the Company. You choose how much you'll contribute to your account through payroll deductions. UnitedHealthcare Insurance Company, a member of the UnitedHealth Group family of companies, through its vendor relationship with HealthEquity, administers the CERA benefit reimbursements.

Contributions	You make pre-tax contributions to your account through payroll deductions up to the annual federal pre-tax limits and after-tax contributions to your account when your eligible commuter expenses exceed those limits. The Company does not make contributions to the CERA.
When Coverage Begins	If you enroll in the CERA by the 10th of the month, your coverage begins on the first day of the following month.
Key Features	■ The CERA can be used to pay for eligible commuter expenses that you incur in the U.S. for transportation to and from your place of employment. ■ You decide how much you want to contribute to your account each month. Then, you can use the money in your account either to pay for or to reimburse yourself for eligible commuter expenses incurred during the year provided you are participating in the CERA.

Your Contributions

You may make pre-tax contributions to your account through payroll deductions up to the annual federal pre-tax limits. If your eligible commuter expenses exceed the annual federal pre-tax limits, you may make after-tax contributions to your account through payroll deductions. The Company does not make contributions to your account. Read the "Contribution Levels" subsection for information about the annual federal pre-tax limits.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Pre-Tax Contributions

Your CERA pre-tax contributions are not subject to most taxes. Your pre-tax contributions aren't taxed when they go into your account or when you withdraw them to reimburse yourself for eligible commuter expenses.

Any pre-tax contributions you make to the CERA also reduce the amount of your earnings that are subject to Social Security tax and the Social Security taxes you pay. Because your pre-tax contributions are exempt from Social Security taxes, the benefits you receive from Social Security in the future may be slightly reduced. For most people, the benefit of the current tax savings will outweigh the possible slight reduction in your future Social Security benefits. For details, see the "Tax Implications of Paying for Your Health Coverage" subsection.

Example — Tax Savings

Here's an example of how your CERA contributions can help you save money. This example assumes your combined gross annual income is $50,000 and you contribute $1,500 to the CERA.

	With CERA Contributions	Without CERA Contributions
Combined Gross Annual Income	$50,000	$50,000
Pre-Tax Contributions	- $1,500	- $0
Taxable Income (W-2 pay)	$48,500	$50,000
*Estimated Federal/FICA Taxes**	- $14,380.25	- $14,825
After-Tax Income	$34,119.75	$35,175.00
Tax Savings	**$1,055.25**	**$0**

* Estimates are based on 2021 tax tables using federal supplemental tax, Social Security and Medicare rates. State taxes have not been included but could represent additional savings if you would have otherwise paid state tax on the money you contribute to your account. The actual amount you save in taxes will depend on your personal situation.

Effect on Other Benefits

Although you reduce your income for tax purposes by participating in the CERA, your total earnings used to determine certain other pay-related benefits are not reduced. For example, your pay used to determine eligible compensation for purposes of the Life Insurance and AD&D Benefit plan, Short-Term Disability plan and Long-Term Disability plan will be unaffected.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

When Benefits Are Paid

The CERA pays reimbursement benefits only for eligible commuter expenses that are:

- Listed in the "Eligible Commuter Expenses" subsection;
- Provided while the person who receives the services is eligible for reimbursement benefits under the CERA; and
- Obtained in accordance with the Plan's terms.

Your CERA Coverage

This section provides additional information, such as how much you can contribute to the CERA, any limits that may apply, and expenses that are and are not eligible for reimbursement.

Contribution Levels

Prior to enrolling in the CERA, you decide how much to contribute to your account through payroll deductions. CERA deductions are taken from your second paycheck each month. You may elect to make pre-tax contributions, up to the annual federal limits, of:

- $270 per month, or $3,240 annually, for eligible transportation expenses; and
- $270 per month, or $3,240 annually, for eligible parking expenses.

Should your election exceed the federal pre-tax limits, you can continue to make contributions for eligible commuter expenses on an after-tax basis.

Keep in mind that you are reimbursed only for eligible commuter expenses that you incur while you are a participant in the CERA. For the purpose of the CERA, expenses are considered incurred on the date you receive the services, not on the date you are billed or charged for the services or pay for the services.

Estimating Your Contributions

To estimate your eligible commuter expenses, simply multiply your expected weekly commuter and/or parking expenses by the number of weeks you expect to use these services. Once you have determined your estimated expenses, you may divide by 12 or the number of months remaining in the calendar year to obtain your monthly anticipated expense. Be sure to consider any holidays or PTO time you plan to take.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Contribution Calculation Example

Here's how contributions are calculated using the assumptions shown below:

Weekly Expenses

$15

Multiplied by Number of Weeks

49 (reduced by 3 weeks of PTO)

Equals Annual Expenses

$735

Monthly Expenses (divide by 12 or number of months remaining in the year)

$61.25

Enrollment must be done by the 10th of each month for your participation to begin the first of the following month. Once you decide how much you wish to contribute each month:

- You may enroll online through https://healthequity.com/learn/commuter. You will be asked to register by creating a username and password and to ensure that your contact information is correct; or
- If you do not have online access, you may contact HealthEquity at 877-311-7849 and speak with a representative to enroll.

Once you enroll, your parking or garage vendor can be paid directly, or if you purchase transit passes, they will be delivered to your home free of charge. You can expect to receive your passes within five to seven business days, depending on your location.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Unused Account Balances

When estimating your contributions, contribute only the amount of money you expect to use. You have the opportunity to elect a different CERA contribution amount each month. Remember that you can only incur eligible expenses while a current employee. If you terminate employment, you will only be permitted to receive reimbursement for eligible commuter expenses incurred before your employment termination date. Any unused account balance will be forfeited.

Also, if you submit eligible claims for reimbursement, you have six months from the date you pay to submit the eligible commuter expense for reimbursement. For example, if you pay your monthly parking expenses for the month of June on June 10, you have until December 10 of the same calendar year to submit the eligible commuter expense for reimbursement.

Eligible Commuter Expenses

The amount that you contribute to the CERA may be used by or reimbursed to you only for eligible commuter expenses. You must incur the expenses for your work-related commuting or parking needs. You can only receive reimbursement for those eligible commuter expenses that are incurred (not billed) during a calendar year while you are participating in (i.e., covered under) the CERA. You cannot use your CERA contributions to pay for expenses you incur before your participation in the CERA begins or after your participation in the CERA ends for that calendar year. Only expenses incurred in the U.S. are eligible.

The claims administrator has the complete discretion as to whether or not an expense is reimbursable and has the authority to request additional information to substantiate your claim for reimbursement.

The following list of eligible commuter expenses is not intended to be comprehensive. It provides examples of commuter and parking expenses that the IRS considers eligible for payment or reimbursement from the CERA.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Examples of expenses that usually or generally are eligible include but are not limited to payments for:

- Commuter expenses for the cost of your daily, weekly or monthly pass, token, fare card or voucher ("transit pass") that you purchase for transportation to your place of employment on a mass transit vehicle, such as a bus or train, or in a commuter highway vehicle that meets certain requirements, including a seating capacity of at least six adults in addition to the driver.

  You must purchase the transit pass through HealthEquity, and HealthEquity will arrange to deduct the cost from your account. Under IRS rules, you cannot be reimbursed for your own purchase of a transit pass unless a pass is not readily available for distribution to you by your employer. In almost all locations of the Company, passes are readily available and must therefore be purchased from HealthEquity.
- The cost of your daily or monthly parking expenses, either at or near your place of employment, or at or near a location from which you commute to work by carpool, vanpool, bus or train.
- Transportation costs if the vehicle used for a vanpool has seating for six or more adult passengers, with 80% of mileage and 50% of seating capacity used for employee transport.
- Direct pay parking expenses paid through a participating parking facility.

Direct Pay Parking Expenses

At some locations, the Company has arranged for employees to pay for parking through payroll deduction. If you use one of these "direct pay" parking facilities, your payments will be deducted from your pay on a pre-tax basis through the CERA Program. The Company will then forward your payments to the participating parking facility.

Employees in Hartford, Connecticut; Phoenix, Arizona; and Boston, Massachusetts

The Hartford, Phoenix and Boston locations feature their own pre-tax payroll deduction program for parking expenses. If you participate in the CERA Program, you will not receive the subsidized parking rate the Company offers through the Hartford, Phoenix or Boston program. **You cannot participate in the Hartford, Phoenix or Boston program and the CERA Program.**

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Commuter Expenses Not Eligible for Reimbursement

The following list of ineligible expenses is not intended to be comprehensive. It provides examples of commuter expenses that the IRS considers not eligible for reimbursement from the CERA.

Examples of expenses that usually or generally are not eligible for reimbursement include but are not limited to payments for:

- Expenses incurred before your date of participation in the CERA;
- Expenses for transportation provided for reasons that are not work-related;
- Toll expenses;
- Expenses that you incur when you are not a participant in the CERA;
- Expenses you incur while a participant in the Hartford, Phoenix or Boston parking plan; and
- Reimbursements for transit passes you buy yourself, if transit passes for your location can be purchased through HealthEquity (contact HealthEquity for more information).

Other Information

This section includes important information about filing CERA claims for reimbursement.

Obtaining CERA Benefits or Filing a Claim for Reimbursement

If you are using HealthEquity Network providers, you do not need to submit a claim for reimbursement. Once you sign up on https://healthequity.com/learn/commuter, you are actually purchasing parking and transit passes online. You then pay for your passes through monthly pre-tax or after-tax payroll deductions.

However, if you choose to pay a parking vendor directly, or if you are using a Non-Network parking provider, you will need to submit a paper receipt for reimbursement to HealthEquity. CERA reimbursement claims are processed daily. Your reimbursement will be included in your next available paycheck.

How to Obtain a Claim Form

You can obtain a “Pay Me Back Claim Form” for reimbursement from the CERA by:

- Accessing https://healthequity.com/learn/commuter and selecting “Popular Forms” then “Commuter – Pay Me Back Claim Form”; or
- Calling HealthEquity.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

How to File a Claim for Reimbursement

When filing a claim for reimbursement, you must substantiate the expense by providing a paper receipt that clearly identifies the eligible commuter expense you have incurred.

Your claim must include:

- A completed “Pay Me Back Claim Form”;
- A receipt verifying the type of commuter expense incurred; and
- The date the commuter expense was incurred and the amount of the charges.

You should send your completed “Pay Me Back Claim Form” and required documentation to the following address:

Claims Administrator
P.O. Box 14053
Lexington, KY 40512
Fax: 877-353-9236

Annual Submission Deadline

You have six months from the date of the initial commuter purchase to submit reimbursement claims incurred during the year of participation. This deadline applies even if you do not continue to make contributions to the CERA for the entire year. However, if your participation ends, you can continue to submit eligible expenses for reimbursement up to the end of the calendar year in which your coverage ended, as long as you are still currently employed by the Company.

How You’ll Receive Your Reimbursement

CERA reimbursement claims are processed daily. Your reimbursement will be included in the next available paycheck after receipt of your completed “Pay Me Back Claim Form” and documentation. Your reimbursements will be paid with pre-tax dollars. These amounts will not be reported as taxable income on your IRS Form W-2.

Account Statements

You can manage your account by logging in to https://healthequity.com/learn/commuter. Log in to your account statement to view your contributions to the account, offset by direct purchases of transit passes or parking passes, or reimbursements for parking. You will not receive any type of Explanation of Benefits (EOB) statement. Once your order for commuter or transit media/fare is placed, however, you will receive a confirmation letter prior to receiving your parking or transit pass.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

How to Check on the Status of a Claim

You may check on the status of a reimbursement claim by:

- Accessing https://healthequity.com/learn/commuter, and:
  - Review your CERA balance and summary information;
  - See examples of eligible and ineligible commuter expenses;
  - Download and print a "Pay Me Back Claim Form" for CERA commuter and parking expenses that are paid out of your pocket; and
  - Read commonly asked questions and answers;
- Calling HealthEquity at 877-311-7849; or
- Accessing https://healthequity.com/learn/commuter within 24 hours upon receipt by HealthEquity.

If Your Claim Is Denied

If you are informed that your claim to purchase transit passes or for reimbursement has been denied, you have the right to appeal that decision. Your rights are explained in the "Claims under the Family Care FSA, CERA, Adoption Assistance Plan, and Tuition Reimbursement Program" subsection.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

This *Critical Illness Insurance* section summarizes the highlights of the Critical Illness Insurance plan. It is not the Summary Plan Description (SPD) for the Critical Illness Insurance plan and is not used to administer the plan. The certificate of coverage issued by UnitedHealthcare Insurance Company, together with the "Introduction" section, "Eligibility and Enrollment" section, "Administrative Information" section, and applicable defined terms in the "Glossary" section of this Handbook, constitute the SPD for the Critical Illness Insurance plan.

You should refer to the certificate of coverage for detailed coverage information. The insurer's certificate of coverage is available on the Benefits Site at https://benefitsenroll.uhg.com.

For the complete details on Critical Illness Insurance:

- Visit the Benefits Site at https://benefitsenroll.uhg.com.
- Refer to the policy at https://cache.hacontent.com/ybr/R516/03742_ybr_ybrfndt/downloads/CICOC.pdf.

For enrollment or general questions, call HRdirect 800-561-0861.

For benefit questions, call the UnitedHealthcare Insurance Company at 800-708-2962.

Questions?

If you have questions about your Critical Illness Insurance plan benefits, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

In This Section **See Page**

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the Critical Illness Insurance Plan Works

The Critical Illness Insurance plan offers a supplement to your health insurance policy to pay benefits when certain losses occur as a result of specified diseases. If you are eligible, coverage is also available for your spouse/domestic partner and your eligible dependent children.

The Critical Illness Insurance plan offers you the choice of coverage options. The Critical Illness Insurance plan is separate from the Medical plan.

You may choose from one of the coverage options. Each option has a maximum benefit amount available. The benefit amount payable is based on the percentages noted for each benefit condition and covered person (employee, spouse or child). See the options listed under "Coverage Levels."

If you are diagnosed with one of the Critical Illnesses listed in the certificate of coverage, you will receive a lump-sum benefit payment. There are three benefit categories. Please review these options carefully before you choose to enroll in this benefit plan.

If you enroll for this coverage, any benefits that are payable are in addition to any other health care coverage you may have.

UnitedHealthcare Insurance Company, a member of the UnitedHealth Group family of companies, insures the Critical Illness Insurance plan's benefits.

Coordination with the Affordable Care Act

This plan is not considered "minimum essential coverage" under the Affordable Care Act, nor is it intended to be a replacement for major medical insurance.

Who Is Eligible

You and your dependents may participate in the Critical Illness Insurance plan if each of you meets the eligibility requirements described in the "Who Is Eligible" subsection.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Coverage Levels

Eligible employees can choose from these coverage levels:

You may choose from one of the following options, which specify the maximum benefit amount available. The benefit amount payable is based on the percentages noted for each benefit category and covered person (employee, spouse or child):

Option	Maximum Benefit Amount
1	■ Employee: $5,000 ■ Spouse/Domestic Partner: $2,500 ■ Child: $1,250
2	■ Employee: $10,000 ■ Spouse/Domestic Partner: $5,000 ■ Child: $2,500
3	■ Employee: $20,000 ■ Spouse/Domestic Partner: $10,000 ■ Child: $5,000
4	■ No Coverage

How to Designate or Change a Beneficiary

To name a designated beneficiary for the first time, or to update your beneficiary, use the following process:

- Visit the Benefits Site at https://benefitsenroll.uhg.com, and click on “Health and Insurance/Critical Illness Insurance” and select “Designate a Beneficiary.” Follow the instructions to enter your beneficiary information, and click the “Continue” button. For your designation to be effective, you must complete this process and save your designation, and you must do so during your lifetime.
- If you do not have Internet access, call HRdirect at 800-561-0861 and talk to a Benefits Advisor.

Filing a Claim

Contact UnitedHealthcare Insurance Company at 800-708-2962 (Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern time). A representative will guide you through the claim process, answer your questions, and tell you what to expect.

You will need to sign and date an Authorization Form and give the completed form to your physician. Please fax a copy of the form to the UnitedHealthcare Insurance Company at 877-286-6011.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

This *Accident Insurance* section summarizes the highlights of the Accident Insurance plan. It is not the SPD for the Accident Insurance plan and is not used to administer the plan. The certificate of coverage issued by UnitedHealthcare Insurance Company, together with the "Introduction" section, "Eligibility and Enrollment" section, "Administrative Information" section, and applicable defined terms in the "Glossary" section of this Handbook, constitute the SPD for the Accident Insurance plan.

You should refer to the certificate of coverage for detailed coverage information. The certificate of coverage and insurance policy documents are available on the Benefits Site at https://benefitsenroll.uhg.com.

For the complete details on Accident Insurance:

- Visit the Benefits Site at https://benefitsenroll.uhg.com.
- Refer to the policy at https://cache.hacontent.com/ybr/R516/03742_ybr_ybrfndt/downloads/Accident.pdf.

For enrollment or general questions, call HRdirect 800-561-0861.

For benefit questions, call the UnitedHealthcare Insurance Company at 800-708-2962.

Questions?

If you have questions about your Accident Insurance benefits, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

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Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the Accident Insurance Plan Works

The Accident Insurance plan is designed to help you and your family by paying fixed benefit amounts based on certain covered injuries or losses for treatments resulting from an accident. If you enroll for this coverage, any benefits that are payable are in addition to any other health care coverage you may have. The Accident Insurance plan is separate from the Medical plan and the Life Insurance plan.

UnitedHealthcare Insurance Company, a member of the UnitedHealth Group family of companies, insures the Accident Insurance plan's benefits.

Coordination with the Affordable Care Act

This plan is not considered "minimum essential coverage" under the Affordable Care Act, nor is it intended to be a replacement for major medical insurance.

Who Is Eligible

You and your dependents may participate in the Accident Insurance plan if each of you meets the eligibility requirements described in the "Who Is Eligible" subsection.

If you are an acquired employee, special eligibility rules apply to you, which are explained in the "Employees Hired during an Acquisition" subsection.

Coverage Levels

If you enroll, you may also cover your spouse or domestic partner and/or your eligible dependent children. No one can be a dependent of more than one employee.

How to Designate or Change a Beneficiary

To name a designated beneficiary for the first time, or to update your designated beneficiary, use the following process:

- Visit the Benefits Site at https://benefitsenroll.uhg.com, and click on "Health and Insurance/Accident Insurance" and select "Designate a Beneficiary." Follow the instructions to enter your beneficiary information, and click the "Continue" button. For your designation to be effective, you must complete this process and save your designation, and you must do so during your lifetime.
- If you do not have Internet access, call HRdirect at 800-561-0861 and talk to a Benefits Advisor.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Filing a Claim

Refer to the certificate of coverage for a checklist of information needed to file a claim. Contact UnitedHealthcare Insurance Company at 800-708-2962 (Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern time). A representative will guide you through the claim process, answer your questions, and tell you what to expect.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UnitedHealth Group Incorporated (UnitedHealth Group or the Company) offers the Group Legal Insurance plan (or the plan). MetLife Legal Plans has the sole and exclusive authority and discretion to interpret the plan's terms and benefits, and to make factual and legal decisions about them.

This *Group Legal Insurance* section summarizes the highlights of the Group Legal Insurance plan. It is not the SPD for the Group Legal Insurance plan and is not used to administer the plan. The MetLife Legal Plans Summary Plan Description, together with the "Introduction" section, "Eligibility and Enrollment" section, "Administrative Information" section, and applicable defined terms in the "Glossary" section of this Handbook, constitute the SPD for the Group Legal Insurance plan.

You should refer to the MetLife Legal Plans Summary Plan Description for detailed coverage information. It is available on the Benefits Site at https://benefitsenroll.uhg.com.

For the complete details on Group Legal Insurance:

- Visit the Benefits Site at https://benefitsenroll.uhg.com.
- Refer to the SPD at: https://cache.hacontent.com/ybr/R516/03742_ybr_ybrfndt/downloads/GroupLegal.pdf.
- Go online to members.legalplans.com.

For enrollment or general questions, call HRdirect 800-561-0861.

For benefit questions, call the MetLife Legal Plans' Client Service Center toll-free at 800-821-6400, 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday. Be prepared to give your Membership Number and ZIP code.

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Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the Group Legal Insurance Plan Works

The Group Legal Insurance plan gives you and your family members access to legal and financial services, attorneys and educational resources.

MetLife Legal Plans is the plan administrator of the Group Legal Insurance plan.

MetLife Legal Plans is the claims administrator for the plan and provides the network of providers.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UnitedHealth Group Incorporated (or the Company) sponsors the UnitedHealth Group Adoption Assistance Plan (the Adoption Assistance Plan or the Plan), which is a component benefit plan of the UHG Inc. Group Benefits Plan. The Adoption Assistance Plan is not subject to ERISA and is not required to be summarized in a Summary Plan Description (SPD).

Even though it is not subject to the SPD requirement, we have prepared this *Adoption Assistance* section, which in combination with the "Eligibility and Enrollment" section, the "Administrative Information" section, and applicable defined terms in the "Glossary" section, summarizes the Plan.

Questions?

If you have questions about your Adoption Assistance Plan benefits, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

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Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the Adoption Assistance Plan Works

The Adoption Assistance Plan reimburses you within certain financial limits for adoption-related expenses that meet the definition of qualified adoption expenses. The Company pays the benefits that are provided through the Plan.

The UnitedHealth Group Employee Benefits Plans Administrative Committee administers the Plan through the Human Capital, Employee Relations function and through HRdirect.

This section includes information about how the Adoption Assistance Plan works, including who is eligible, participating in the Plan, cost of benefits, when benefits are paid, and when participation begins and ends.

When Benefits Are Paid

Subject to the "Special Rules That Affect When Benefits Are Paid" below, the Adoption Assistance Plan pays benefits only for qualified adoption expenses that are:

- Listed in the "Schedule of Benefits" (under the "Your Adoption Assistance Plan Benefits" subsection);
- Incurred while you are participating in the Plan; and
- Incurred in accordance with the Plan's terms.

Special Rules That Affect When Benefits Are Paid

- **As a general rule, you must be actively at work** at the time you incur a qualified adoption expense. The Plan will, however, reimburse you for qualified adoption expenses that you incur while you are on an approved leave of absence for the purpose of adopting an eligible child, but will reimburse you only if you return to being actively at work after the leave of absence. You may submit your claim form while on leave (within the 90-day filing deadline), but payment will not be made until you are actively at work.
- **If your employment ends because of a corporate downsizing before** your adoption of an eligible child is final or the eligible child is placed in the home (temporary legal custody), the Plan will reimburse you for qualified adoption expenses that you incur prior to the date your employment ends and while you participate in the Plan, if:
  - The adoption is legally finalized or the home placement is confirmed (temporary legal custody) within six months of your employment termination date;
  - You incurred the expenses on or before the last day you were actively at work; and
  - You file a claim for reimbursement for the qualified adoption expenses within 30 days of the date the adoption is legally finalized or once the home placement is confirmed (temporary legal custody).

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- **If you voluntarily terminate your employment before** your adoption is legally final or the child is placed in the home (temporary legal custody), the Plan will not reimburse you for any qualified adoption expenses you incur before your employment ends.
- **If you voluntarily terminate your employment after** your adoption is legally final or the home placement is confirmed (temporary legal custody), the Plan will reimburse you for any qualified adoption expenses you incur before your employment ends. You must, however, file a claim for reimbursement for the qualified adoption expenses before your employment ends.
- **If you die while you are employed and a participant in the Plan**, the Plan will reimburse your family or representative after the adoption of an eligible child is legally final or the eligible child is placed in the home (temporary legal custody), for qualified adoption expenses that:
  - You incurred prior to your death; and/or
  - Your family incurs within three months of your death.

In either case, your surviving spouse or domestic partner or your other representative must file a claim for reimbursement for the qualified adoption expenses within 30 days of the date the adoption is legally final or the eligible child is placed in the home (temporary legal custody). Benefits will be paid to your surviving spouse or domestic partner, and if you have none, to your estate.

Your Adoption Assistance Plan Benefits

The Adoption Assistance Plan reimburses you for qualified adoption expenses you incur in adopting an eligible child(ren), once the home placement is confirmed (temporary legal custody) or the adoption is legally final. If you reside in a state that requires court approval of adoptions, the Plan will not recognize your adoption as final until the date that the court issues a final adoption decree or judgment. If you adopt an eligible child from another country in an international adoption, the Plan will not recognize your adoption as final until you have met the state law adoption requirements of the state in which you reside.

The following “Schedule of Benefits” describes the qualified adoption expenses for which the Adoption Assistance Plan pays benefits and the maximum benefits that are payable for each adoption of an eligible child.

The maximum benefits that are payable by the Plan are different for regular full-time employees and for regular part-time employees.

The benefits that the Plan pays may be excludable from your taxable income. The tax consequences of reimbursements from the Plan are summarized in the “Tax Consequences of Reimbursements from the Plan” subsection.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

Schedule of Benefits

Adoption Benefit Maximum

- Regular full-time employees: $10,000 per eligible child
- Regular part-time employees (working at least 20 and fewer than 35 hours per week): $5,000 per eligible child

Qualified Adoption Expenses

- Public and private adoption agency fees, including foreign adoption fees
- Legal fees and court costs
- Uninsured medical expenses for the adopted child
- Uninsured medical expenses for the birth mother
- Temporary foster care expenses for care immediately preceding placement of the child with the adopting family
- Filing and placement fees
- Immigration and naturalization fees
- Immunization and translation fees
- Traveling expenses associated with the adoption, including transportation, meals and lodging

Adoption Expenses That Are Not Covered

The adoption-related expenses listed in this section are not covered by the Plan, and the Plan will not reimburse you for them. This list is not all-inclusive but identifies the more common expenses that the Plan does not cover, such as expenses that you:

- Incur before you become a participant in the Plan;
- Incur in connection with a surrogate parenting arrangement;
- Incur in making voluntary donations to an orphanage or adoption agency;
- Incur for personal items that you purchase for you (or your spouse or domestic partner) and/or the eligible child, during or after the adoption is legally final or the child is placed in the home (temporary legal custody), such as clothing;
- Do not actually pay or that are not payable by you;
- Incur for professional counseling for the adopted child's biological parents;
- Incur in establishing a legal guardianship;

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- Have been or will be reimbursed by another source (i.e., another employer's plan or any federal, state or local plan);
- Have taken or will take a deduction or tax credit for;
- Incur in violation of a state or federal law; or
- Incur for an adoption that is not legally final.

Other Information

This section provides information on filing a claim for reimbursement and on tax consequences associated with receiving reimbursements from this Plan.

Filing a Claim for Reimbursement

You must pay any qualified adoption expenses you incur, and then request reimbursement from the Plan. The Plan does not pay expenses for you. To receive reimbursement for expenses, you must file a claim within 90 days after the date your adoption of an eligible child is legally final or at the time the eligible child is placed in the home (temporary legal custody).

However, this claim deadline is different in four special situations that are explained in "Special Rules That Affect When Benefits Are Paid" in the "When Benefits Are Paid" subsection.

If both you and your spouse or domestic partner are eligible employees under this Plan, only one of you may claim reimbursement for the qualified adoption expenses that either or both of you incur.

How to Obtain a Claim Form

You can obtain the "Adoption Assistance Plan Reimbursement Request Form" by visiting the Benefits Site at https://benefitsenroll.uhg.com and clicking on "Additional Benefits/Adoption Assistance."

How to File a Claim

You must submit your claim form within 90 days following the date the adoption is legally final or once the child is placed in the home (temporary legal custody), unless one of the special situations applies to you that are explained in "Special Rules That Affect When Benefits Are Paid" in the "When Benefits Are Paid" subsection. Complete the "Adoption Assistance Plan Reimbursement Request Form," including the "Certification for Reimbursement," by which you certify that the expenses for which you claim reimbursement have not been reimbursed by any other source, and that you have not taken and will not take a tax credit for the expenses for which you claim reimbursement.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

- Attach a copy of:
  - Your receipts, bills or invoices (in U.S. dollars) including the expenses incurred;
  - Evidence that you paid the expenses (i.e., canceled checks or paid invoices); and
  - Your final adoption decree.
- To submit your claim, mail the completed claim form and the required documentation to the address listed on the "Adoption Assistance Plan Reimbursement Request Form." Your claim will not be paid unless you submit the completed claim form and the required documentation by the applicable deadline.

Allow a minimum of two to four weeks for the claims administrator to process your claim. Special circumstances may require an extension of the processing time.

If your claim is approved, payment will be made to you in your regular biweekly paycheck for the next biweekly pay period that ends after your claim is approved. Read the "Tax Consequences of Reimbursements from the Plan" subsection for the tax consequences of, and tax reporting that applies to, reimbursements from the Plan.

In the rare event that you receive a reimbursement that is greater than the total amount payable to you, the Company has the right to a refund of such excess amounts. You will be asked to repay, and will be responsible for repaying, the difference between the benefit you received and the amount that should have been paid under the Plan.

Tax Consequences of Reimbursements from the Plan

This section summarizes the federal tax rules under IRS Code Section 137 that apply to the adoption assistance benefits the Plan provides. This is not intended to be tax advice, and your personal tax situation is unique. You are advised to consult with your own tax advisor.

IRS Code Section 137 permits the Plan's reimbursement to you for certain adoption-related expenses to be excludable by and nontaxable to you, subject to certain dollar limits on the amounts excludable and on your modified adjusted gross income.

IRS Code Section 137 also permits you to take an income tax credit for certain adoption-related expenses; but it does not allow you to receive a nontaxable reimbursement and take a tax credit for the same adoption expense.

Both the exclusion and the tax credit are subject to certain dollar limits and an income limit, which are briefly explained in the following paragraphs.

This explanation only summarizes the highlights of these rules, and the Company cannot provide and is not providing tax or legal advice to you. Every situation is unique and complicated, and we encourage you to consult your professional tax advisor on how and when to exclude reimbursements from your taxable income and how to coordinate the tax credit with the exclusion.

We also encourage you to review IRS Form 8839, "qualified adoption expenses," and the accompanying instructions for more information. They are available on the IRS website at www.irs.gov.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Exclusion of Plan's Reimbursements

IRS Code Section 137 permits you to exclude from your taxable income up to $14,440 per child (in 2021) in reimbursements you receive from an employer-sponsored adoption assistance plan (including the Plan) for many, but not all, adoption expenses. This limit is adjusted annually for cost-of-living increases. This amount is reduced or phased out when your modified adjusted gross income (modified AGI) exceeds certain thresholds, which we explain in "Income Limits" below.

Most of the Plan's benefits are permitted by IRS Code Section 137, and are nontaxable to you, if:

- You don't receive adoption assistance benefits from any other employer plan that would cause your reimbursements to exceed the per child maximum exclusion;
- Your exclusion is not limited because of your adjusted gross income; and
- You do not take a tax credit for the same expenses for which you receive reimbursement from the Plan.

While most of the reimbursements the Plan makes are permitted by IRS Code Section 137, the Plan does pay benefits for some expenses that are not excludable, which makes them taxable to you. A common example of a taxable payment is the Plan's reimbursement of expenses you or your spouse or domestic partner incurs in adopting a stepchild. They are not excludable under IRS Code Section 137, so the Plan's reimbursement of them is taxable to you.

Adoption Expense Tax Credit

The tax credit for certain adoption expenses is subtracted from your federal income tax liability. The maximum credit for 2021 is $14,400 per child and is adjusted annually for cost-of-living increases. The tax credit is subject to certain dollar limits and an income limit, which we briefly explain in "Income Limits" below.

Interaction between the Exclusion and the Tax Credit

The interaction between the exclusion and the tax credit, and the rules that determine whether a particular expense is reimbursable or eligible for the tax credit under IRS Code Section 137 and whether the exclusion or tax credit is limited by the income limits, are very complex. You may claim a tax credit and exclude certain adoption-related expenses, but you cannot claim a tax credit for expenses for which you receive reimbursement under this Plan or any other employer-sponsored plan. You are encouraged to seek the advice of your personal tax advisor.

You may be able to claim tax credit for expenses that exceed the reimbursements you receive if your adoption expenses:

- Are permitted by IRS Code Section 137;
- Exceed the adoption benefit maximum you receive from the Plan ($10,000 for regular full-time employees and $5,000 for regular part-time employees);
- Are not reimbursed from any other employer-sponsored plan; and
- If your exclusion and tax credit aren't completely phased out because of your modified AGI.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Income Limits

The exclusion and tax credit amount are reduced if your modified AGI exceeds $216,660 and are completely phased out if your modified AGI reaches $256,660. These amounts are subject to annual cost-of-living adjustments. The modified AGI limits that affect the tax credit and exclusion are determined by IRS Code Section 137.

Tax Withholding and Reporting on Reimbursements

The Company pays the reimbursements under the Plan to you in a regular biweekly paycheck, once they are approved. As a general rule, the Company assumes that the reimbursements that are paid to you are excludable by and nontaxable to you, and does not perform income tax withholding on them. The Company is, however, required to apply FICA and FUTA withholding on all such nontaxable reimbursements as they are paid to you. At year-end, any reimbursements you've received during the calendar tax year are reported in box 12 of your IRS Form W-2 and are identified with the letter "T." These reimbursements are not included with your taxable wages in box 1 of your IRS Form W-2.

An exception to this general rule, however, is that if the Plan reimburses you for expenses related to adoption of a stepchild (which are not excludable under IRS Code Section 137 and are taxable to you), the Company will treat the reimbursement as taxable income to you and perform income and FICA and FUTA withholding when the Plan reimburses you, and will report it as taxable income in your year-end IRS Form W-2.

You are responsible for determining whether any reimbursements you receive from the Plan are taxable or nontaxable to you, and for including taxable reimbursements in your taxable income. If you later determine that a reimbursement the Plan makes to you is includable in your income and taxable to you, it is your responsibility to adjust your IRS Form 1040 to include the taxable portion of the reimbursement in your gross income. You may also need to adjust your income tax withholding (IRS Form W-4) or make estimated tax payments to avoid potential penalties for underpayment of tax on the taxable portion of a reimbursement. You should consult your tax advisor for more complete information.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

An Example

Mike is a regular full-time employee who is married to Katie, who works elsewhere. They file a joint federal income tax return and have adopted an eligible child who is not a stepchild.

Mike and Katie paid $10,000 of qualified adoption expenses in 2020 and an additional $8,000 in 2021 (a total of $18,000). The adoption was final in 2021. The Adoption Assistance Plan reimbursed Mike for $10,000 of these expenses in 2021. Mike and Katie did not receive reimbursement from any other employer-sponsored adoption assistance plan. Mike and Katie's adjusted gross income was $88,000 in 2021. Since it was less than the IRS income limit ($216,660 in 2021), their potential exclusion and tax credit are not reduced.

They may exclude the Program's $10,000 reimbursement from their income in 2021. They may also be able to claim a tax credit for the remaining $8,000 of qualified adoption expenses because the amount falls under the maximum Adoption Expense Tax Credit of $14,400 (see the "Adoption Expense Tax Credit" subsection).

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UnitedHealth Group Incorporated (UHG or the Company) sponsors the UnitedHealth Group Tuition Reimbursement Program (the Program), which is a benefit plan under the UHG Inc. Group Benefit Plan. As a qualified educational assistance program under Internal Revenue Service Code Section 127, a separate written document is required for the Program, and reasonable notification of the availability and terms of the Program must be communicated to eligible employees. The Tuition Reimbursement Program is not subject to ERISA and is not required to be summarized in a Summary Plan Description (SPD). Even though it is not subject to the SPD requirement, we have prepared this *Tuition Reimbursement* section, which in combination with the "Introduction" section, the "Eligibility and Enrollment" section, the "Administrative Information" section, and applicable defined terms in the "Glossary" section, summarizes the Program.

How to Obtain the Written Program Document

- This *Tuition Reimbursement* section of the Handbook is not the Program document, but rather provides information about its key provisions. You can obtain a copy of the Tuition Reimbursement Program document (and accompanying forms to apply for tuition reimbursement) by:
  - Visiting the Benefits site at https://benefitsenroll.uhg.com and clicking on "Additional Benefits/Tuition Reimbursement"; or
  - Calling HRdirect at 800-561-0861.

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Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How the Tuition Reimbursement Program Works

The Tuition Reimbursement Program provides assistance in paying qualifying education costs for eligible employees who seek to improve their current job skills and are approved to enroll in outside educational courses. The Program reimburses you for approved education expenses at 100% (up to an annual maximum) when you meet Program requirements. The UnitedHealth Group Employee Benefits Plans Administrative Committee administers the Program. There is no charge to participants for coverage under the Tuition Reimbursement Program, and you do not need to elect to participate. You must, however, receive pre-approval before enrolling in a course.

Your Tuition Reimbursement Program Benefits

The Tuition Reimbursement Program will reimburse you for 100% of approved expenses for approved courses, subject to the Program's requirements, including that the course directly relates to your current job and that you obtain a certain grade in the course. There is also an annual maximum reimbursement amount that caps reimbursements; see the Tuition Reimbursement Program document (available by calling HRdirect or on the Benefits Site at https://benefitsenroll.uhg.com) for additional information.

The annual maximum reimbursement amount is greater for regular full-time employees than for regular part-time employees.

- You can take courses at any time outside of normal scheduled work hours. **Note:** Manager approval is required if you wish to take courses scheduled during work hours.
- Subject to the annual maximum reimbursement, there is no limit to the number of courses you can take.

You must obtain prior approval by completing the Tuition Reimbursement Pre-Approval Application Online Form, or you will not be reimbursed.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UnitedHealth Group (UHG or the Company) sponsors the UnitedHealth Group Severance Pay Plan (the Severance Plan or the Plan). The Plan is a benefit of the UHG Inc. Group Benefits Plan and is governed by ERISA. Benefit plans/programs that are subject to ERISA must be summarized in a Summary Plan Description (SPD). This *Severance Pay* section in the Handbook is not the SPD for the Plan, and is not used to administer the Plan. It merely provides general information about the Plan's eligibility rules and the benefits the Plan provides.

You can read or obtain a copy of the UnitedHealth Group Severance Pay Plan and Summary Plan Description (Severance Pay Plan SPD) online by visiting the Benefits Site at https://benefitsenroll.uhg.com.

You can also request a paper copy of the Severance Pay Plan SPD by calling HRdirect at 800-561-0861.

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How the Severance Pay Plan Works

The Severance Pay Plan provides severance benefits to certain eligible employees whose employment is involuntarily terminated by the Company under certain conditions. Review the Severance Pay Plan SPD and/or other documents on the Benefits Site at https://benefitsenroll.uhg.com or https://cache.hacontent.com/ybr/R516/03742_ybr_ybrfndt/downloads/SEVPOL.pdf for the details of the Plan.

If you are an acquired employee who became employed by UHG through the acquisition of an acquired employer, special eligibility and/or benefit rules may apply to you for a limited period of time after the acquisition. If these special rules apply, you will get more information in a Transition Guide and Calendar or similar document. You can also find out more information about special acquisition rules in the Severance Pay Plan document.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

UHG is the plan administrator of the Severance Pay Plan. UHG has delegated the authority to decide claims under the Plan to a Severance Claim Committee. Benefits under the Severance Pay Plan are paid from UHG's general assets. There is no charge to participants for coverage under this Plan, and you do not need to elect to participate.

If you are hired as, or become, an eligible employee, you will be covered under the Plan automatically. You are not eligible for benefits, however, unless you have a qualifying termination and satisfy other Plan terms, including but not limited to signing a valid Severance Agreement and Release in the form and manner required by UHG.

Who Is Eligible for Coverage

You are eligible for coverage under the Severance Pay Plan if:

- You work for a participating employer and you are classified on both the payroll and the personnel records as a regular full-time or regular part-time employee; and
- You have not entered into an employment agreement or other separate agreement with UHG that gives you a right to severance or other separation benefits.

Who Is Eligible for Severance Benefits

You are eligible for severance benefits if:

- Your employment ends because of a qualifying termination;
- You sign and do not revoke a Severance Agreement and Release that UHG provides to you; and
- You meet certain other requirements.

UHG determines, in its discretion, whether your employment ends as a result of a qualifying termination, and whether you are eligible for severance benefits.

Your Severance Pay Plan Benefits

- The benefits you may be eligible to receive under the Plan are determined by your base pay (and certain commissions if you are classified in a sales band), your years of service based on your last start date, and your grade level or sales band as they are in effect when your employment ends.
- Special rules apply that limit or affect the amount of severance benefits the Plan will pay.
- Special rules apply to you if you have a break in service and are rehired by the Company.
- The benefits that are payable under the Plan are taxable compensation and subject to payroll tax withholding.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

The *Administrative Information* section contains information that applies to the following benefit plans of the UHG Inc. Group Benefits Plan that are described in this Handbook and that are subject to ERISA: the Critical Illness Insurance plan, Accident Insurance plan and Group Legal Insurance plan (Group Legal) (collectively, the ERISA Plans). (The Severance Pay Plan's administrative information is contained in the Severance Pay Plan Summary Plan Description [SPD] located on the Benefits Site https://benefitsenroll.uhg.com.) This section also contains information that applies to plans not subject to ERISA.

Additionally, this section provides certain plan administration information as well as claims and appeals procedures and your legal rights under ERISA.

Questions?

If you have questions about your benefits under any of the Plans/Programs, visit the Benefits Site at https://benefitsenroll.uhg.com or contact HRdirect at 800-561-0861.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

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Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

General Administrative Information

Effective Date of Summary Plan Descriptions	January 1, 2021, except as otherwise noted in the Handbook.
Plan Year	January 1 through December 31.
Plan Name	UHG Inc. Group Benefits Plan
Plan Number	530
Plan Sponsor	UnitedHealth Group Incorporated is the Plan Sponsor of the UHG Inc. Group Benefits Plan. The Plan Sponsor's mailing and street address for courier delivery is: UnitedHealth Group Incorporated c/o Corporate Benefits Department MN008-R120 9900 Bren Road East Minnetonka, MN 55343 The plan sponsor's phone number is: 952-936-1300
Plan Sponsor's Employer Identification Number (EIN)	41-1321939.
Plan Administrator	The UnitedHealth Group Employee Benefits Plans Administrative Committee is the plan administrator of the UHG Inc. Group Benefits Plan. The plan administrator's mailing and street address is: UnitedHealth Group Employee Benefits Plans Administrative Committee c/o Corporate Benefits Department MN008-R120 9900 Bren Road East Minnetonka, MN 55343 The plan administrator's phone number is: 952-936-1300

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Agent for Service of Legal Process	The agent for service of legal process is the UnitedHealth Group's Office of the General Counsel. The agent's mailing and street address for courier delivery is: Office of the General Counsel UnitedHealth Group Incorporated MN008-T700 9900 Bren Road East Minnetonka, MN 55343 The agent's phone number is: 952-936-1300 Legal process can also be served on the plan administrator, through its Corporate Benefits Department at its mailing or courier delivery address.

Assignment of Benefits

In general, you cannot assign, transfer or convey any of the benefits provided by the plans/programs. You may, however, assign certain rights under the Life Insurance and AD&D Benefit plan. See the applicable section of this Handbook for more information.

Administrative Information for Component Benefit Plans

The information in this section applies to the following component benefit plans under the UHG Inc. Group Benefits Plan:

- Family Care FSA
- CERA
- Critical Illness Insurance
- Accident Insurance
- Group Legal Insurance
- Adoption Assistance Plan
- Tuition Reimbursement Program

For the Severance Pay Plan, view the Severance Pay Plan SPD on the Benefits Site at https://benefitsenroll.uhg.com or https://cache.hacontent.com/ybr/R516/03742_ybr_ybrfndt/downloads/SEVPOL.pdf.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Family Care FSA and CERA

Plan Name	Family Care FSA	CERA
Plan Type	Non-ERISA benefit plan that permits pre-tax contributions for dependent care reimbursement benefits.	Non-ERISA benefit plan that permits pre-tax contributions for transportation expense reimbursement benefits.
Source of Contributions	Employee contributions.	Employee contributions.
Type of Administration	Third-party administration through UnitedHealthcare Insurance Company.	Third-party administration through UnitedHealthcare Insurance Company, for services through HealthEquity.
Funding/Trust/Trustee	No trust. Dependent care expense benefits are paid from the employee's Dependent Care Reimbursement Account (DCRA). EAP-related benefits are paid by UnitedHealth Group from its general assets.	No trust. Transportation expense reimbursement benefits are paid from the employee's Commuter Expense Reimbursement Account. CERA-related benefits are paid by UnitedHealth Group from its general assets.
Contact for Review of Denied Claims	UnitedHealthcare P.O. Box 981506 El Paso, TX 79998-1506 Phone: 800-357-1371	HealthEquity Processing Center P.O. Box 69310 Harrisburg, PA 17106-9310 Phone: 877-311-7849
Where to Send Claims	UnitedHealthcare P.O. Box 981506 El Paso, TX 79998-1506 Phone: 800-357-1371 Fax: 915-231-1709 Toll-Free Fax: 866-262-6354	HealthEquity Processing Center P.O. Box 69310 Harrisburg, PA 17106-9310 Phone: 877-311-7849 Fax: 717-651-2383
Contact for Plan Documents	HRdirect Service Center MN008-R120 9900 Bren Road East Minnetonka, MN 55343 Phone: 800-561-0861	HRdirect Service Center MN008-R120 9900 Bren Road East Minnetonka, MN 55343 Phone: 800-561-0861
Subject to ERISA	No.	No.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Critical Illness Insurance

Plan Name	Critical Illness Insurance
Plan Type	ERISA welfare benefit plan that provides critical illness insurance benefits.
Source of Contributions	Employee pays full cost of coverage.
Type of Administration	Insurer administration
Funding/Trust/Trustee	The plan is insured through UnitedHealthcare Insurance Company.
Claims Administrator for Review of Denied Claims	UnitedHealthcare Insurance Company P.O. Box 7466 Portland, ME 04112-7466 Phone: 800-708-2962
Where to Send Claims	UnitedHealthcare Insurance Company P.O. Box 7466 Portland, ME 04112-7466 Phone: 800-708-2962
Contact for Plan Documents	HRdirect Service Center MN008-R120 9900 Bren Road East Minnetonka, MN 55343 Phone: 800-561-0861
Subject to ERISA	Yes.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Accident Insurance

Plan Name	Accident Insurance
Plan Type	ERISA welfare benefit plan that provides insurance benefits in the event of certain covered injuries or losses.
Source of Contributions	Employee pays full cost of coverage.
Type of Administration	Insurer administration.
Funding/Trust/Trustee	The plan is insured through UnitedHealthcare Insurance Company.
Claims Administrator for Review of Denied Claims	UnitedHealthcare Insurance Company P.O. Box 7466 Portland, ME 04112-7466 Phone: 800-708-2962
Where to Send Claims	UnitedHealthcare Insurance Company P.O. Box 7466 Portland, ME 04112-7466 Phone: 800-708-2962
Contact for Plan Documents	HRdirect Service Center MN008-R120 9900 Bren Road East Minnetonka, MN 55343 Phone: 800-561-0861
Subject to ERISA	Yes.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Group Legal Insurance

Plan Name	Group Legal Insurance
Plan Type	ERISA welfare benefit plan that provides access to legal and financial services, attorneys and educational resources.
Source of Contributions	Employee pays full cost of coverage.
Type of Administration	Third party administration through MetLife Legal Plans, Inc.
Funding/Trust/Trustee	There is no trust. Benefits are paid by the Company from its general assets.
Claims Administrator for Review of Denied Claims	MetLife Legal Plans, Inc. Director of Administration 1111 Superior Avenue, Suite 800 Cleveland, OH 44114-2507
Where to Send Claims	MetLife Legal Plans, Inc. 1111 Superior Avenue, Suite 800 Cleveland, OH 44114-2407
Contact for Plan Documents	MetLife Legal Plans, Inc. 1111 Superior Avenue, Suite 800 Cleveland, OH 44114-2407
Subject to ERISA	Yes.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Adoption Assistance Plan and Tuition Reimbursement Program

Plan/Program Name	Adoption Assistance Plan	Tuition Reimbursement Program
Plan Type	Non-ERISA benefit plan that provides adoption assistance benefits.	Non-ERISA benefit program that provides tuition reimbursement benefits.
Source of Contributions	Employees do not contribute to the cost of this Plan.	Employees do not contribute to the cost of this Program.
Type of Administration	The Company self-administers the Plan.	The Company self-administers the Program.
Funding/Trust/Trustee	There is no trust. Benefits are paid by the Company from its general assets.	There is no trust. Benefits are paid by the Company from its general assets.
Claims Administrator for Review of Denied Claims	UnitedHealth Group Incorporated c/o Employee Relations MN008-W210 9900 Bren Road East Minnetonka, MN 55343 Phone: 952-936-1300	UnitedHealth Group Incorporated c/o Talent Management MN008-W210 9900 Bren Road East Minnetonka, MN 55343 Phone: 952-936-1300
Where to Send Claims	UnitedHealth Group Incorporated c/o Employee Relations MN008-W210 9900 Bren Road East Minnetonka, MN 55343 Phone: 952-936-1300	UnitedHealth Group Incorporated MN008-W210 9900 Bren Road East Minnetonka, MN 55343 Phone: 952-936-1300
Contact for Plan and Program Documents	HRdirect Service Center MN008-R120 9900 Bren Road East Minnetonka, MN 55343 Phone: 800-561-0861	HRdirect Service Center MN008-R120 9900 Bren Road East Minnetonka, MN 55343 Phone: 800-561-0861
Subject to ERISA	No.	No.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Claim and Appeals Procedures — ERISA Plans

For ERISA Plans

If you participate in Critical Illness Insurance, Accident Insurance or Group Legal Insurance (the ERISA plans), you have rights under ERISA to bring a claim for benefits, and to appeal a denial of your claim for benefits. For the Severance Pay Plan, refer to that separate SPD for claim and appeals procedure information. The section for each of the ERISA plans explains how to file a claim for benefits under each of them. This "Claim and Appeals Procedures" subsection provides additional information about making a claim for benefits under each of them, and describes your appeal rights if your claim for benefits is denied. It also explains the deadlines by which you must file a claim or an appeal of a denied claim, the claims administrators' deadlines for responding to your appeal, and your right to pursue litigation if you are dissatisfied with the applicable plan's final decision on your claim. You must follow and complete the claim and appeals procedure before you can bring a lawsuit, and you must comply with the deadline to sue.

Status of the Claims Administrator as a Fiduciary

The claims administrator for each ERISA plan is a fiduciary with respect to the applicable plan. The claims administrator has the exclusive right and discretion, with respect to claims and appeals, to interpret the plan's terms, to administer the plan's benefits, to determine the applicable facts and to apply the plan's terms to the facts. The claims administrator's decisions are conclusive and binding on all parties.

Claims for Benefits under the ERISA Plans

The "Filing a Claim for Benefits" explanation in the section for each of the ERISA Plans explains how to file a claim for benefits.

Your Deadline to File a Claim

Unless the individual section of the Handbook for a particular benefit plan provides a different deadline, you must bring your claim for benefits within one year after the date you know or reasonably should know the principal facts upon which your claim is based. If you file a claim after this deadline, it will be denied automatically.

Where to File a Claim

The tables in the "Administrative Information for Component Benefit Plans" subsection list the addresses at which you may file a claim under each of the ERISA plans.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

The Claims Administrator's Decision on Your Claim

The claims administrator will respond in writing (delivered by paper or electronically) to all claims, whether the claim is granted or denied. The claims administrator will also notify you in writing (delivered by paper or electronically) if your claim under an applicable plan is denied. Any denial, reduction or termination of a benefit or failure to provide or make payment for (in whole or in part) a benefit is a claim denial. The written claim denial will include the reason for the denial, reference to the relevant plan provision(s) on which the denial is based and other information that is required by federal regulation.

Timing of Claim Decisions and Appeals under the ERISA Plans

The following table lists the time periods within which the claims administrator must respond to your claim for benefits and your appeal of a denied claim, as well as your deadlines for taking action to complete a claim and file an appeal of a denied claim.

Claims under Critical Illness Insurance, Accident Insurance and Group Legal Insurance

Type of Claim or Appeal	Timing of Action or Response
If your claim is complete when filed and is denied, you will be notified in writing within:	90 days after receipt of your claim.
If the claims administrator determines that special circumstances require an extension of time for processing your claim and notifies you in writing before the end of the initial determination period, the determination period may be extended an additional:	90 days.
If the claims administrator again determines that special circumstances require an extension of time for processing your claim and notifies you in writing before the end of the first extension period, the determination period may be extended an additional:	Not applicable.
If the extension is necessary due to your failure to submit necessary information, you must submit that information in writing within:	60 days. Note: The time period for deciding your claim is stopped from the date the claims administrator sends you the extension notification until the date you respond to the request for additional information, or if earlier, after 60 days.
You must appeal a denied claim in writing within:	60 days after receipt of the claim denial notice.
The claims administrator must notify you of its determination on appeal in writing within:	60 days after receipt of the appeal.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Type of Claim or Appeal	Timing of Action or Response
If the claims administrator determines that special circumstances require an extension of time for processing your appeal and notifies you in writing before the end of the appeal determination period, the determination period may be extended an additional:	60 days.
If the extension is necessary due to your failure to submit necessary information, you must submit that information in writing within:	60 days. Note: The time period for deciding your claim is stopped from the date the claims administrator sends you the extension notification until the date you respond to the request for additional information, or if earlier, after 60 days.

Appeals of Denied Claims under the ERISA Plans

If your claim is denied, you can appeal the denial. You may also submit written comments, documents, records and other information relevant to your claim. Upon written request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to the denial of your claim. To ask for copies of this information, contact the claims administrator for the applicable plan.

The tables in the "Administrative Information for Component Benefit Plans" subsection list the addresses to which you may file a written appeal of a denied claim under each of the ERISA plans.

Your Deadline to File an Appeal

You must file an appeal within the deadlines that are listed in the "Timing of Claim Decisions and Appeals under the ERISA Plans" table (in the "Claims for Benefits under the ERISA Plans" subsection). If you file an appeal after the applicable deadline, it will be denied automatically.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

How to File an Appeal

You or your authorized representative can appeal the denial of your claim. You must file the appeal with the claims administrator for the applicable plan at the address listed in the "Administrative Information for Component Benefit Plans" subsection. Generally, your appeal must be in writing and include:

- Your name;
- The reason you believe the claim should be paid or coverage should be provided; and
- Any documentation or other written information to support your claim.

Appeal Process

In deciding an appeal, the claims administrator will take into account all comments, documents, records and other information submitted to support the appeal without regard to whether the information was submitted in connection with the claim for benefits.

Deadlines for Deciding Appeals

The claims administrator must decide and respond to your properly submitted and complete appeal within a reasonable time, and no later than the deadlines that are listed in the "Timing of Claim Decisions and Appeals under the ERISA Plans" table in the "Claims for Benefits under the ERISA Plans" subsection.

The Claims Administrator's Decision on Your Appeal

The claims administrator will respond in writing (delivered by paper or electronically) to all appeals. If your appeal is denied, the written denial will include the reason for the denial, reference to the relevant plan provision(s) on which the denial is based and other information that is required by federal regulation. If your appeal is denied, upon written request you have the right to reasonable access to and copies of, free of charge, all documents, records and other information relevant to the denial of your appeal.

Your Remedy If Your Claim and Appeals Are Denied

If your claim for benefits and your appeals are denied, your sole remedy under the ERISA plans is to bring an action under ERISA Section 502(a) to recover any benefits you think the applicable plan owes to you. You can bring suit in the U.S. District Court and for the District of Minnesota unless the terms of an insured plan specify a different venue. Before bringing suit, you must first exhaust the claim review and appeal procedures.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Your Deadline to Bring a Lawsuit

Unless the individual section of the Handbook for a particular benefit plan provides a different deadline, if you file your claim within the required time and complete the entire claim and appeals procedure, you must commence any lawsuit within six months after the claim and appeals procedure is complete. In all events, you must commence the lawsuit within one year after the date you know or reasonably should know the principal facts upon which your claim is based.

Exhaustion of Claim and Appeals Procedure

Completing the claim and appeals procedure is mandatory for resolving every claim and dispute arising under the plans subject to ERISA and discussed in this "Administrative Information" section. In any legal action brought after you have exhausted the claim and appeals procedure, all determinations made by the claims administrator will be afforded the maximum deference permitted by law.

Claims for Benefits under Certain Non-ERISA Plans

The "Filing a Claim for Benefits" explanation is in the "Family Care FSA" section, "Commuter Reimbursement" section, "Adoption Assistance Plan" section, and "Tuition Reimbursement Program" section.

Where to File a Claim

The tables in the "Administrative Information for Component Benefit Plans" subsection list the addresses at which you may file a claim under the Family Care FSA, the CERA, the Adoption Assistance Plan, and the "Tuition Reimbursement Program" section.

The Plan Administrator's Decision on Your Claim

The plan administrator will respond in writing (delivered by paper or electronically) to your claim, whether the claim is granted or denied.

Timing of Claim Decisions and Appeals under Certain Non-ERISA Plans

The following table lists the time periods within which the plan administrator will respond to your claim for benefits and your appeal of a denied claim, as well as your deadlines for taking action to complete a claim and file an appeal of a denied claim.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Claims under the Family Care FSA, CERA, Adoption Assistance Plan and Tuition Reimbursement Program

Type of Claim or Appeal	Timing of Action or Response
If your claim is complete when filed and is denied, you will be notified in writing within:	90 days after the claim is filed.
If the plan administrator determines that special circumstances require an extension of time for processing your claim and notifies you in writing before the end of the initial determination period, the determination period may be extended an additional:	90 days.
You must appeal a denied claim in writing within:	60 days after receipt of the claim denial notice.
The plan administrator must notify you of its determination on appeal in writing within:	60 days after you file a request for review.
If the plan administrator determines that special circumstances require an extension of time for processing your appeal and notifies you in writing before the end of the appeal determination period, the initial determination period may be extended an additional:	60 days.
You may file a written request for a second appeal within:	Not applicable.

Appeals of Denied Claims under Certain Non-ERISA Plans

You or your authorized representative can appeal the denial of your claim. You must file the appeal with the plan administrator for the applicable plan at the address listed in the table in the "Administrative Information for Component Benefit Plans" subsection, and within the timeframe listed in the "Timing of Claim Decisions and Appeals under Certain Non-ERISA Plans" table above.

Generally, your appeal must be in writing and include:

- Your name;
- The reason you believe the claim should be paid or coverage should be provided; and
- Any documentation or other written information to support your claim.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

The Plan Administrator's Decision on Your Appeal

The plan administrator will decide and respond to your properly submitted and complete appeal within a reasonable time, and no later than the deadlines that are listed in the "Timing of Claim Decisions and Appeals under Certain Non-ERISA Plans" table above. If you file an appeal after the applicable deadline, it will be denied automatically. The plan administrator will respond in writing (delivered by paper or electronically) to your appeal.

Your Remedy If Your Claim and Appeals Are Denied

If your claim for benefits and appeals are denied, your sole remedy under the Family Care FSA, the CERA Program, the Adoption Assistance Plan, and the Tuition Reimbursement Program is to submit the claim to binding arbitration under the UnitedHealth Group Employment Arbitration Policy.

Your Rights under ERISA

These ERISA rights and protections apply only to the ERISA plans and do not apply to any of the Non-ERISA plans. If you are enrolled in any of the Company's benefit plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA) and described in this "Administrative Information" section, ERISA provides certain rights and protections to you as follows:

Obtain Information about Your Plan and Benefits

You have the right to certain information about the ERISA plans and your benefits under them, including the right to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, certain documents governing the Plan, including the applicable plan document, if any, insurance contracts and any collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the
- U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of certain documents governing the Plan, including the UHG Inc. Group Benefits Plan document, other applicable plan documents, insurance contracts, any collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) for the Plan. The plan administrator may make a reasonable charge for the copies.
- Request and receive a copy of the Handbook.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called “fiduciaries” of the plans, have a duty to administer the plans prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these ERISA rights:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court if you have exhausted the Plan’s claims procedures.
- In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court if you have exhausted the Plan’s claims procedures.
- If a Plan fiduciary misuses the applicable Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the costs and fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim to be frivolous.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

Assistance with Your Questions

For answers to questions about the ERISA Plans, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

For case management, advance approval, forms, questions or provider directories for the plans addressed in this Handbook, refer to the contact information below.

For information on claim submission and appeal processes, see the "Administrative Information" section for the other plans.

Plan	Name and Phone Number	Web Address
Family Care Flexible Spending Account	HRdirect: 800-561-0861	https://benefitsenroll.uhg.com
Commuter Expense Reimbursement Account	HRdirect: 800-561-0861 HealthEquity: 877-311-7849	https://healthequity.com/commuter
Critical Illness Insurance	UnitedHealthcare Insurance Company: 800-708-2962	https://benefitsenroll.uhg.com
Accident Insurance	UnitedHealthcare Insurance Company: 800-708-2962	https://benefitsenroll.uhg.com
Group Legal Insurance	MetLife Legal Plans: 800-821-6400	www.legalplans.com
Adoption Assistance Plan	HRdirect: 800-561-0861	https://benefitsenroll.uhg.com
Tuition Reimbursement Program	HRdirect: 800-561-0861	https://benefitsenroll.uhg.com
Severance Pay Plan	HRdirect: 800-561-0861	https://benefitsenroll.uhg.com

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

This section provides definitions of common terms that apply to one or more of the benefits described in this Handbook.

Acquired Employee

An individual who is an employee of an acquired employer on the day that UHG or one of its affiliates acquires the acquired employer and who becomes an employee of UHG or its affiliate as a direct result of the acquisition.

Acquired Employer

An entity that UHG, or one of its affiliates, acquires in an acquisition.

Acquisition

A corporate transaction, such as a stock purchase, asset purchase or similar transaction, through which UHG or one of its affiliates acquires an acquired employer and the acquired employer is determined to be a member of the UHG control group.

Actively at Work or Active Work

For purposes of Critical Illness Insurance, Accident Insurance and the Adoption Assistance Plan, means you are physically present at your regular worksite, or an alternative site if on official UHG business, with the intent and ability to work the scheduled hours and perform the normal duties of your job.

Actively at work includes regularly scheduled days, holidays and vacation days, as long as you are capable of active work on those days. If you are incapable of active work on the day before your coverage effective date because of a medical condition, your coverage will not begin until you complete a full day of active work as an eligible employee.

Adoption Benefit Maximum

The maximum amount the Plan will reimburse to you for all qualified adoption expenses that you or your spouse or domestic partner incurs in adopting an eligible child. The adoption benefit maximum is $10,000 for eligible employees who are regular full-time employees, and $5,000 for eligible employees who are regular part-time employees.

Note: Please refer to the “Glossary” section if you are unfamiliar with a particular word or phrase.

The Hub or Benefits Site

The online resources that explain or contain the Company's policies, procedures, forms, handbooks and other information related to benefits, compensation, payroll, employment practices and policies, and other Human Capital-related matters. The websites are accessible when you're at work via The Hub, UHG's intranet home page, and is accessible when you're at home through https://hub.uhg.com or https://benefitsenroll.uhg.com.

Code

The United States Internal Revenue Code of 1986, as amended from time to time.

Consistency Rule

The federal tax rule that requires that a change you make to your pre-tax benefit elections under the Family Care FSA under the life event rules be on account of and consistent with the life event you experience. The consistency rule is explained in the "Life Events and the Consistency Rule" subsection.

Coverage Effective Date

Your coverage effective date is different for different benefits and is stated in the "What You Need to Know to Enroll" subsection. If you are a newly hired eligible employee, your coverage effective date for many benefits is the first day of the month following your hire date, and for others it is your hire date. If you are a newly reclassified eligible employee, your coverage effective date for many benefits is the first day of the month following the effective date of your reclassification as an eligible employee, and for others it is the date your reclassification is effective.

Day Care Centers

If care is provided at a day care or elder/dependent care center, to be eligible, the center must comply with all state and local regulations that apply to these centers. A center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, even if the center is not run for profit.

Domestic Partner

A person who meets the definition of a domestic partner, which is stated in the "Eligible Dependents" subsection.

Eligibility Date

The date or dates as of which a newly hired eligible employee or an existing newly reclassified and newly eligible employee is first eligible to elect some or all of the benefit plans that are summarized in this Handbook.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Eligible Child

A person who is younger than age 26 or a person of any age who is physically or mentally incapable of caring for himself or herself, and is:

- Your child or another child who is related to you; or
- The child of your spouse or domestic partner.

Eligible Commuter Expenses

Commuter and parking expenses that are:

- Defined in the "Eligible Commuter Expenses" subsection;
- Provided while the person who incurs the expenses is eligible to participate in and is covered under the CERA; and
- Obtained in accordance with the CERA's terms.

Eligible Dependents

The persons whom you can elect to enroll in coverage under Critical Illness Insurance and/or Accident Insurance, and with respect to whose eligible expenses you can request reimbursement from the Family Care FSA. They are defined more thoroughly in the "Eligible Dependents" subsection.

Eligible Dependent Care Expenses

Expenses for dependent care incurred by an eligible employee to enable the eligible employee to be gainfully employed for any period during which the eligible employee has one or more eligible Family Care FSA dependents and which are defined as "employment-related expenses" under Code Section 21(b)(2). In addition, if the eligible employee is married, the eligible employee's spouse must be gainfully employed, a full-time student, or unable to care for himself or herself in order for an expense to qualify as an eligible dependent care expense.

The expense is incurred when the dependent care is provided, and not when the eligible employee is formally billed for, charged for or pays for the dependent care.

The claims administrator has the final authority and discretion to determine whether any expense is an eligible dependent care expense.

No expenses may be claimed as eligible dependent care expenses if the eligible employee takes a tax credit for child and dependent care expenses for those same expenses on his or her individual federal income tax return. IRS Publication 503, "Child and Dependent Care Expenses," provides more information about this federal income tax credit.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Eligible Employees

The classes of employees the Company has determined are eligible to participate in some or all of the benefit plans that are described in this Handbook, as listed in the "Eligible Employees" subsection.

UHG's classification controls the employee's eligibility or ineligibility, even if the classification is in error or UHG subsequently agrees to a reclassification.

Eligible Family Care FSA Dependent

A person who is:

- A child who is the eligible employee's Family Care Flexible Spending Account (Family Care FSA) dependent child;
- The eligible employee's spouse:
  - Who is physically or mentally unable to care for himself or herself;
  - Whose principal place of abode is the same as the eligible employee's for more than one-half of the year;
  - Who regularly spends at least eight hours a day in the eligible employee's household; and
- Any other person:
  - For whom the eligible employee provides support for more than one-half of the year;
  - Who is a member of the eligible employee's household;
  - Who is physically or mentally unable to care for himself or herself;
  - Whose principal place of abode is the same as the eligible employee's for more than one-half of the year; and
  - Who regularly spends at least eight hours a day in the eligible employee's household.

Enrollment Deadline

The deadline or deadlines by which an eligible employee must take action to enroll in many of the benefit plans that are explained in this Handbook. There are three different enrollment deadlines:

- The initial enrollment deadline, the date by which a newly hired or reclassified eligible employee must take action to enroll in coverage under certain benefit plans for the first time. The initial enrollment deadline is the 30th day following the eligible employee's hire date or reclassification as an eligible employee.
- The Open Enrollment deadline, the deadline that is identified from year to year in the "Benefits Enrollment Guide" that is provided to eligible employees shortly before the start of the annual Open Enrollment Period.
- The life event deadline, the date by which an eligible employee must take action to enroll in or change coverage under certain benefit plans during the calendar year. See the **"**Life Events" section for the deadlines per each type of event.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

Evidence of Insurability (EOI)

Information that the insurer requires that you provide or a physician examination the insurer requires that you undergo before it will approve your coverage.

Expatriate

Any existing employee relocated by UHG across an international country border for the purpose of continuing employment with UHG. Typically, these are for assignments lasting more than six months but not more than five years.

Family Care FSA/Dependent Care Reimbursement Account (DCRA) Dependent Child

A child:

- Who is younger than age 13 at the time the dependent care expense is incurred, unless he or she is otherwise considered a qualified dependent;
- Whose principal place of abode is the same as the eligible employee's for more than one-half of the taxable year; and
- Who does not provide over one-half of his or her own financial support for the taxable year.

FICA

Under the Federal Insurance Contributions Act, FICA taxes shown on your IRS Form W-2 represent your contributions toward your Social Security coverage and Medicare.

Grace Period Extension

If you are covered under and contributing to the Family Care FSA as of the last day of the calendar year and have money left over in your Family Care FSA account on that date, you can continue to incur eligible dependent care expenses during the grace period extension (which is January 1 – March 15 of the following calendar year) and receive reimbursement from any amounts remaining at the end of the prior calendar year.

Hire Date

For purposes of determining eligibility of a newly hired employee to participate in UHG's benefit plans (and subject to all of the terms of the plans), the first day as of which the newly hired person is entered as an employee on the payroll and personnel records of UHG or an affiliate.

For purposes of determining the eligibility of an acquired employee to participate in UHG's benefit plans (and subject to all of the terms of the plans), special rules apply that are explained in the Transition Guide and Calendar or similar document for each acquisition and/or in separate materials that are provided to acquired employees shortly before they become eligible to participate.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Initial Enrollment Deadline

The 30th day following your hire date or reclassification as an eligible employee.

Life Events

Certain events that commonly occur in your personal and professional life, which, under federal law, allow you to change your pre-tax benefit elections under the Family Care FSA if your election also complies with any consistency rule that may apply. They are explained in the "Life Events and the Consistency Rule" subsection.

Network Provider

A provider who has entered into an agreement with HealthEquity to provide eligible commuter expenses at a discounted rate.

Non-Network Provider

A provider who has not entered into an agreement with HealthEquity and who is free to set the rates for eligible commuter expenses.

Open Enrollment Period

The annual period during which eligible employees have an opportunity to change their coverage elections and contribution levels under certain of UHG's benefit plans for the next calendar plan year. The annual Open Enrollment Period typically occurs in October each year, but it can vary from year to year.

Participating Employer

An affiliate of UHG that UHG permits to participate in all or some of the benefit plans that are explained in this Handbook. The affiliates that are permitted to participate are listed in the "Participating Employers" subsection. The list of participating employers changes from time to time, in UHG's discretion.

Plan Administrator

The UnitedHealth Group Employee Benefits Plans Administrative Committee (the Committee) serves as the plan administrator to administer the benefit plans described in this Handbook. The plan administrator (and any other persons or entities to whom the plan administrator delegates fiduciary authority and duties) has the sole and exclusive authority and discretion to interpret the benefit plans' terms and benefits under them, and to make factual and legal decisions about them.

The plan administrator has the authority to delegate, and has delegated, certain authority and duties to other parties, who are third-party administrators, fiduciaries and/or trustees.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Qualified Adoption Expenses

The reasonable and necessary adoption fees and expenses that are directly related to, and that you incur in:

- A domestic or foreign adoption of an eligible child through an agency licensed by the state in which you reside; or
- A private adoption of an eligible child if permitted by law in the state in which you reside;

and that are:

- Listed in the Schedule of Benefits in the "Your Adoption Assistance Plan Benefits" section;
- Incurred for an adoption that is legally finalized while you are eligible to participate in and are covered under the Adoption Assistance Plan;
- Incurred for an adoption that is legally finalized while you are actively at work for the Company, unless you are on an approved leave of absence for the purpose of adopting an eligible child; and
- Not reimbursed to you or your spouse or domestic partner by any other employer-sponsored plan or by any other source.

Regular Full-Time Employee

- An employee of a participating employer who is classified on the U.S. payroll and personnel records of the participating employer as an employee who is regularly scheduled to work at least 35 hours per week and as an employee who is not a collectively bargained employee.

Regular Part-Time Employee

- An employee of a participating employer who is classified on the U.S. payroll and personnel records of the participating employer as an employee who is regularly scheduled to work 1-34 hours per week (regardless of the hours actually worked) and as an employee who is not a collectively bargained employee.

Spouse

A person who meets the definition of a spouse, which is stated in the "Eligible Dependents" subsection.

Temporary Employee

An individual who is hired by an affiliate of UHG to work a full-time or part-time schedule for a special project(s) or on a short-term or intermittent basis, and who is classified on its payroll and personnel records as a temporary employee.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.

Transition Guide and Calendar

The guide or similar document that is prepared for each acquisition that explains the manner in which acquired employees who are eligible employees will become eligible to participate in UHG's benefit plans. The terms of the Transition Guide and Calendar vary from acquisition to acquisition. The name of the Transition Guide and Calendar may also change from time to time.

UHG Inc. Group Benefits Plan

The UHG Inc. Group Benefits Plan is UHG's formal ERISA plan. The benefit plans described in this Handbook are all components of the UHG Inc. Group Benefits Plan.

Note: Please refer to the "Glossary" section if you are unfamiliar with a particular word or phrase.