UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO) PLAN

SUMMARY PLAN DESCRIPTION: SUPPLEMENT TO EVIDENCE OF COVERAGE

January 1, 2023

INFORMATION IN THIS SUPPLEMENT

ABOUT THIS SPD SUPPLEMENT

This summary plan description supplement to the evidence of coverage (the "supplement") includes important eligibility and administrative information about the UnitedHealthcare Group Medicare Advantage (PPO) Plan (the "Plan") sponsored by UnitedHealth Group (the "Plan Sponsor" or the "Company"). It also contains important information about your rights under ERISA.

This supplement does not fully describe your coverage. For details on your benefits, please refer to the Plan's Evidence of Coverage (the "EOC"). The EOC will contain information about the medical care and prescription drugs covered through the Plan, out of pocket expenses for which you may be responsible, requirements you must satisfy before receiving services, and the services and expenses that are excluded under the Plan. In no event will the Plan pay any benefits beyond what is described in the EOC.

This supplement, together with the EOC for the Plan, serves as both the plan document and the Summary Plan Description ("SPD") for the Plan. Please keep this supplement with your EOC. If there is a discrepancy between this supplement and the EOC, the terms of the EOC will control. No discrepancy between this supplement and the EOC shall be deemed to occur merely because this summary contains provisions that do not appear in the EOC, or vice versa.

This supplement has been prepared by UnitedHealth Group for the Plan. Neither the receipt of this supplement nor the use of the term "you" indicates that you are eligible for a benefit under the Plan. Only those individuals who satisfy the eligibility requirements and other criteria are eligible for a benefit. Neither the receipt of this supplement nor the terms of the Plan creates a right for you to be retained in employment.

This supplement provides an overview of the Plan but does not give all the details. You must read the EOC to have a complete understanding of the Plan. If you have questions about benefits or eligibility, please contact UnitedHealthcare Customer Service at 866-868-0501 or visit www.UHCRetiree.com/uhg.

INTRODUCTION

UnitedHealth Group maintains the Plan to provide medical and prescription drug coverage to Medicare-eligible retirees and dependents through a Medicare Advantage PPO.

The following is a list of some terms used in this supplement:

- **Insurer**. The "Insurer" is UnitedHealthcare Insurance Company.
- **Participant**. You become a Participant in the Plan once you satisfy the eligibility requirements and enroll in the Plan.
- **Participating Employer**. The Plan is offered to eligible employees of employers that participate in more or more of the following health and welfare plans:
    - UHG Inc. Group Benefits Plan
    - Optum Partner Services Health and Welfare Benefits Plan
    - OptumCare Group Benefits Plan
- **Plan**. UnitedHealthcare Group Medicare Advantage (PPO) Plan.
- **Plan Administrator**. The "Plan Administrator" is the UnitedHealth Group Employee Benefits Plans Administrative Committee.
- **Plan Number**. The "Plan Number" is 531.

- **Plan Sponsor**. The “Plan Sponsor” is UnitedHealth Group Incorporated.
- **Year**. The term “Year” generally refers to a “Plan Year.” A “Plan Year” is the 12-month calendar year, from January 1 through December 31.

ELIGIBILITY AND PARTICIPATION

Eligible Former Employees and Board of Director Members

Generally, you are eligible to participate in the Plan if you retire or terminate employment with a Participating Employer on or after October 1, 2019, and, at the time you retire or terminate employment:

- You are eligible for benefits under the UHG Inc. Group Benefits Plan, , Optum Partner Services Health and Welfare Benefits Plan, or OptumCare Group Benefits Plan, and
- **You are classified on both the U.S. payroll and the personnel records of the Participating Employer as a regular full-time employee or regular part-time employee.**

You are also eligible to participate in the Plan if you are a former employee of a Participating Employer and:

- Prior to your termination of employment, you were classified on both the U.S. payroll and the personnel records of the Participating Employer as a regular full time employee or regular part time employee,
- You enrolled in group health plan continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) through the UHG Inc. Group Benefits Plan, Optum Partner Services Health and Welfare Benefits Plan, or OptumCare Group Benefits Plan, and
- Your COBRA continuation coverage ended on or after October 1, 2019.

You may enroll in the Plan at any time following your termination of employment or the end of your COBRA continuation coverage, provided you are Medicare eligible and have a valid Medicare enrollment period.

Additionally, current members of the UnitedHealth Group Incorporated Board of Directors or members that retired on or after October 1, 2019 are eligible to enroll in the Plan. Further, if the former employee or board member enrolls in the Plan, their Medicare-eligible dependents (spouse/domestic partner and children) may enroll in the Plan.

Please note: in addition to the general eligibility rules in this supplement, there may be additional eligibility rules for the Plan that are specified in the EOC.

Ineligible Former Employees. Individuals who are classified as follows are not eligible to participate in the Plan:

- Former employees who were nonresident aliens not receiving earned income in the United States.
- Former employees employed by a Participating Employer outside of the United States.
- Former employees classified on U.S. payroll and personnel records as a temporary employee.
- Individuals who were classified as leased employees, independent contractors, or other classification that was not a common law employee.

Even if you satisfy the general requirements to participate, if you are in one of these categories or classifications, you are not eligible to participate. An individual’s classification shall be determined based on the Participating Employer’s payroll and personnel records. Any re classification of an individual,

whether by a court, governmental agency, or otherwise, shall not result in the individual being eligible for the Plan prior to the date of the re classification.

Eligible Dependents

To be eligible for coverage under the Plan, your dependent must meet the following requirements.

- If you are an active U.S. based employee, classified as a regular full time or regular part time employee, and you are eligible for benefits under the UnitedHealth Group Benefits Plan, Optum Partner Services Health and Welfare Benefits Plan or OptumCare Group Benefits Plan, your eligible dependents include your Medicare eligible:
    - Spouse,
    - Domestic Partner
    - Parents
    - Step-parents
    - Siblings
    - Grandparents
    - Aunts
    - Uncles
    - Same family members listed above through marriage.

  You must complete an attestation of eligibility before enrolling one or more of the family members described above. To complete the attestation form, visit www.UHCRetiree.com/uhg.

- If you are an eligible former employee or board member (as described in "Eligible Former Employees and Board of Director Members" above) and you enroll in the Plan, your eligible dependents include your Medicare-eligible:
    - Spouse,
    - Domestic Partner, and
    - Children.

Proof of Dependent Status. The Plan Administrator and Insurer reserve the right to request documentary proof, at any time, of the eligibility or continued eligibility of any dependent under the Plan. The Plan Administrator or Insurer may, in their discretion, take corrective action if you do not send proof of a dependent's eligibility either when requested during the enrollment process or within 30 days after a later request, or if they otherwise find that your dependent is not eligible.

Enrollment and Effective Date of Coverage

You or your eligible dependent(s) may enroll in the Plan at any time permitted by Medicare enrollment rules. Your coverage will be effective on the date your application is approved by the Centers for Medicare & Medicaid Services ("CMS"). For more information about enrollment periods and signing up, please refer to the Medicare website (www.medicare.gov) and click on the "Sign Up/Change Plans" link.

When Coverage Ends

Generally, coverage will end at the time and for the reasons described in the EOC. In addition to the reasons coverage may end listed in the EOC, coverage under this Plan automatically ends on the last day of the month in which the earliest of the following occurs:

For Eligible Former Employees and Board of Director Members:

- The Company amends or terminates the Plan for any reason;
- You fail to pay required premiums when they are due;
- You elect to terminate coverage; or
- You cease to be eligible to participate in the Plan.

For Eligible Dependents:

- The Company amends or terminates the Plan for any reason;
- You fail to pay required premiums when they are due;
- You elect to terminate coverage; or
- You cease to be an eligible dependent under the Plan.

For Both Eligible Former Employees/Board of Director Members and Eligible Dependents:

The Plan Administrator or Insurer 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, UnitedHealth Group's staff, a provider or another covered person;
- Engages in or permits or assists another in committing fraud on the Plan and/or in submitting false information regarding eligibility for coverage or payment of benefits;
- Violates the terms of the Plan; or
- Engages in or permits another in engaging in in appropriate or unauthorized use of your Medicare Advantage card.

CLAIMS

The EOC sets forth the claim procedures for the Plan. Please refer to the EOC for more information.

Time Limits for Bringing a Claim. Unless a shorter period is provided in the EOC, in which case the shorter period shall apply, you must submit your claim to the claim administrator within twelve (12) months after the earlier of the date on which (1) you were denied benefits, (2) you received benefits at a different level that you believed the Plan provides, or (3) you knew or reasonably should have known of the principal facts on which your claim is based. It is important that you include all of the facts and arguments that you want considered during the claim procedures.

Exhaustion of Administrative Remedies. You must exhaust the Plan's claims and appeal procedure to resolve every claim and dispute arising under the Plan before you may bring any legal action. In any subsequent legal action all explicit and implicit determinations made under the procedure shall be afforded the maximum deference permitted by law.

Time Limits for Bringing a Lawsuit. Unless a shorter time period is provided in the EOC, in which case the shorter period shall apply, no legal action to recover Plan benefits or to enforce or clarify rights under the Plan or ERISA or any other law may be brought by you, unless the legal action is commenced in the proper forum before the earlier of:

- Six (6) months after you have exhausted the claim and appeal procedure; or
- Twelve (12) months after the earlier of the date (a) you were denied benefits; (b) you received benefits at a different level that you believed the Plan provides, or (c) you knew or reasonably should have known of the principal facts on which your claim is based.

Choice of Law and Venue. Except to the extent that federal law is controlling, the Plan shall be construed and enforced in accordance with the laws of the state of Minnesota (except that the state law will be applied without regard to any choice of law provisions).

In addition, any claim or action with respect to the Plan shall be brought in the United States District Court for the District of Minnesota.

PLAN AMENDMENT AND TERMINATION

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

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.

If the 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 for charges incurred prior to the effective date of the amendment or termination.

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

If the 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 contract or otherwise determined by the Company.

You are not vested in any benefits under the Plan.

CONTACT INFORMATION

Plan Name

UnitedHealthcare Group Medicare Advantage (PPO) Plan (the “Plan”).

Plan Number

The plan number is 531.

Group Number is 13478.

Plan Year

January 1 through December 31.

Plan Sponsor

UnitedHealth Group Incorporated is the Plan Sponsor of UnitedHealthcare Group Medicare Advantage (PPO) Plan.

The Plan Sponsor’s mailing and street address 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)

The Plan Sponsor’s federal taxpayer identification number (“EIN”) is: 41-1321939.

Insurer, Claim Administrator and Named Claim Fiduciary

The Insurer, Claim Administrator and Named Claim Fiduciary is:

UnitedHealthcare Insurance Company
P.O. Box 30770
Salt Lake City, UT 84130-0070

Telephone: 866-868-0501

Hours of operation: 8 a.m–8 p.m. local time, Monday–Friday.

www.UHCRetiree.com

You may also refer to Section 2 of the EOC for more detailed contact information for the Insurer, Claim Administrator and Named Claim Fiduciary.

Plan Administrator

The UnitedHealth Group Employee Benefits Plans Administrative Committee is the Plan Administrator of UnitedHealthcare Group Medicare Advantage (PPO) Plan.

The Plan Administrator's mailing address and street address 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.

You are responsible for making sure the Plan Administrator has your current mailing address.

ADDITIONAL INFORMATION

Assignment of Benefits

Except as permitted by the EOC, you, your dependents or any beneficiary may not pledge, assign, encumber or alienate any rights you may have under the Plan or ERISA to anyone else (including the right to file claims or appeals, the right to request documents under the Plan or a program, and the right to bring a lawsuit seeking benefits, penalties, damages or equitable relief against the Plan, a program or their fiduciaries). Additionally, the Company will not recognize any assignment of your rights to benefits or any other rights under ERISA, or any attachment, garnishment or execution following judgment or other legal process. You cannot assign your benefits (or any other right under ERISA) to any provider of health care services.

Funding and Payment of Your Benefits

The Plan is fully insured and the benefits are paid by the Insurer.

Fees and Expenses

Fees and other expenses incurred by the Plan may be paid by the Plan.

The Plan permits the Plan Administrator to determine how to allocate expenses incurred by the Plan. Those expenses may be charged:

- In the same amount to the accounts of all Participants and beneficiaries.
- In the same percentage over all or certain assets.
- In the case of individualized expenses, allocated to an individual Participant or beneficiary.

The Plan Administrator may change its method of allocating expenses incurred by the Plan. Contact the Plan Administrator if you have any questions regarding the Plan's payment or allocation of expenses incurred by the Plan.

Plan Administration

The Plan Administrator is the UnitedHealth Group Employee Benefits Plans Administrative Committee, with UnitedHealthcare, the Insurer, acting as claim administrator with regard to claims for benefits and appeals relating to medical and prescription drug coverage.

The Plan Administrator will make determinations that may be required from time to time in the administration of the Plan and will have the sole authority, discretion and responsibility to interpret and apply the terms of the Plan and to determine all factual and legal questions under the Plan. The Plan Administrator also has the authority and discretion to delegate its authority to another entity.

Because claims administration, as previously noted, is provided by the Insurer, the Plan Administrator has delegated to the Insurer the sole authority, discretion and responsibility to interpret and apply the terms of the Plan and to determine all factual and legal questions under the Plan as related to claims administration for medical and prescription drug coverage, including determining eligibility for benefits and the amounts of benefits to be paid, and administering claims for benefits and appeals.

The Insurer is responsible for the payment of all benefits offered under the Plan. No covered former employee, dependent or other person shall have any claim or cause of action against UnitedHealth Group as to the payment of benefits under any insurance policy or contract. Each covered person or other claimant entitled to the payment of benefits under the Plan shall look solely to the applicable insurance policy with UnitedHealthcare for payment of such insured benefits.

Receipt of Documents

If a form or document must be filed with or received by the UnitedHealth Group Corporate Benefits Department, the Plan Administrator, or the Insurer, it must be actually received by the appropriate entity to be effective. The appropriate entity shall determine whether a document was received.

Agent for Service of Legal Process

The agent for service of legal process is the Office of the General Counsel. The agent's mailing address and address for courier delivery is:

Office of the General Counsel
UnitedHealth Group
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 at its mailing address or courier delivery addresses.

Type of Plan

The Plan is an employee welfare benefit plan providing medical and prescription drug benefits.

SPECIAL NOTICES AND ERISA RIGHTS

To the extent not otherwise set forth in the EOC the following provisions will apply, as applicable.

Maternity or Newborn Infant Coverage

Under federal law, group health plans and health insurance issuers generally may not restrict medical benefits for a mother or her newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or to less than 96 hours following a cesarean section. Federal law does not generally prohibit the health care provider attending the mother or the newborn child, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours or 96 hours, as applicable. Plans and issuers may not require a provider to obtain preauthorization for prescribing the length of stay during the first 48 hours or 96 hours, if applicable, after the birth.

Post-Mastectomy Coverage

Under federal law, if you receive benefits under the Plan in connection with a mastectomy and elect breast reduction construction, group health plans and health insurance issuers generally must provide coverage in a manner determined in consultation with the attending physician and the patient for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Coverage is subject to the same deductibles and coinsurance limitations that apply to the mastectomy treatment.

Protected Health Information

Under the Health Information Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the Plan are required to take steps to ensure that certain "protected health information" is kept confidential. These rights and requirements are outlined in the notice of privacy practices provided by the Insurer.

ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

- Examine, without charge, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor. You may review these documents at the Plan Administrator's office and at other specified locations. The Form 5500 is also available for inspection at the Public Disclosure Room of the Employee Benefits Security Administration.
- Receive copies of documents governing the operation of the Plan, including copies of the latest Form 5500 and updated summary plan description, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- 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.

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 plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, 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 administrator. After you exhaust the Plan's claim procedures, following an adverse benefit determination on review, you may file suit in federal court.

In addition, after you exhaust the Plan's procedures for reviewing medical child support orders, following an adverse determination or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions. If you have any questions about your Plan, 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, D.C. 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.