UnitedHealthcare's COVID-19

Frequently Asked Questions

October 27, 2021

TABLE OF CONTENTS

KEY RESOURCES – COVID-19

- UnitedHealthcare Summary of COVID-19 dates on uhc.provider.com
- CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again
- CDC COVID-19 Site - what you should know, situation updates, community impacts and resources
- Families First Act and CARES Act FAQ
- FAQ guidance (ACA FAQs Part 43)
- FDA Fact Sheet Serological Test for Antibodies and FDA Diagnostic Testing FAQs
- Health and Human Services Coronavirus Resources
- CDC Travel recommendations
- UnitedHealthcare COVID-19 FAQ
- IRS Notice on High Deductible Plans with HSA
- Family First Coronavirus Response Act (H.R. 6201)
- Symptom Checker
- Test Locator Tool
- Emotional Support line 866-342-6892 available 24/7
- Sanvello press release
- External ASO Options Guide New 4/19/21
- UnitedHealthcare/OptumRx Community Circle Fighting COVID-19 Together

- DOJ Reporting COVID-19 suspected scams: Fraud Hotline call **1-866-720-5721** or email disaster@leo.gov
- FDA Approved Tests
- Back to Worksite Toolkit – Employer eServices (EeS), United eServices (UeS) or other secure platform (UMR, All Savers, Sierra)
- FAQ: What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws
- National emergency guidance and timing
- Telehealth Reimbursement Policy – EXTERNAL

VACCINES

Keeping you up to date on the latest developments for a COVID-19 vaccine is our top priority. It will be an important way to slow the spread of the disease. That's why we are committed to helping you find vaccine information and get the vaccine. Your health care provider can help you understand more about the vaccine and your health.

PRESIDENTS 6-POINT COVID-19 RESPONSE PLAN

New 9/13/21

On Thursday, September 9, 2021, the President unveiled a six-point COVID-19 response plan focused on 1) vaccinating the unvaccinated, 2) providing further protections for the vaccinated, 3) keeping schools safely open, 4) increasing testing and masking, 5) protecting economic recovery, and 6) improving care for those with COVID-19.

The plan includes requiring more than 80 million Americans working in the private sector to receive a COVID-19 vaccine or product negative test results at least once a week. It is expected that these new regulations will be issued by the Occupational Safety and Health Administration (OSHA) in the coming weeks and apply to companies with 100 or more employees.

In addition, the executive orders require most federal employees and contractors doing business with the federal government to get the COVID-19 vaccine. This will apply to approximately 50,000 providers and a majority of health care workers that work in settings receiving Medicare or Medicaid reimbursement.

The plan also mentions increasing the supply of tests and reducing the cost of at-home tests and includes the purchase of 280,000,000 rapid tests that will be distributed to support long-term care facilities, community testing sites, critical infrastructure, shelters serving individuals experiencing homelessness, prisons and jails, and other vulnerable populations and congregate settings.

We are evaluating what the Sept. 9 announcement might mean and once additional guidance is released, we will provide updates for brokers, consultants, and customers. UnitedHealthcare COVID-19 FAQs will updated as more information is known.

What is unknown at this time but should be included in updated guidance is who is expected to cover the costs for the weekly testing for unvaccinated members — the government, the individual who is not vaccinated, the employer, or the insurer. UnitedHealthcare's policy is to cover testing for employment, education, public health, or surveillance purposes only when required by applicable law. Information on COVID-19 surveillance testing and other policies can be found on the uhc.com health and wellness site.

The FDA has approved the COVID-19 vaccine for use in preventing serious illness from COVID-19 among people ages 16 and older. COVID-19 vaccines are also emergency-use authorized (EUA), among people age 12 and older to help prevent serious illness from COVID-19, by the FDA.

- Comirnaty (Pfizer) - requires 2 doses
- Moderna - requires 2 doses
- Johnson and Johnson - requires 1 dose

To support members, customers, and providers with COVID-19 vaccination, UnitedHealthcare has informed members that there is $0 cost-share for their vaccination through the national public health emergency period. We continue to provide resources to help members find COVID-19 vaccine information and provide communications to help encourage vaccination and encourage members to discuss vaccinations with their health care provider. The Covid-10 Vaccine Resource locator at uhc.com/vaccinelocator helps people access COVID-19 vaccination providers.

GENERAL VACCINE INFORMATION

Should members pay to get their name on a COVID-19 vaccination list? New 2/10/2021

No. Be on alert for fraud. If someone calls, texts, or emails you promising access to the vaccine for a fee, don't share your personal or financial information.

- No one should ask you to pay to put your name on a list to get the vaccine.
- No one should ask you to pay to get early access to a vaccine

You can report suspected fraud to UnitedHealthcare, and we'll help you file a report, which could help you and others. Members can learn more about how to protect themselves from fraud on uhc.com.

What are the main things to know about COVID-19 vaccines? Update 10/27/2021

- COVID-19 vaccines are an important step in slowing the spread of the disease and are key to protecting people's health. UnitedHealthcare encourages members to talk to their health care provider about the right time to get their COVID-19 vaccine. As part of our COVID-19 vaccination program, we are committed to helping remove barriers to vaccination, focused on building vaccine confidence and supporting equitable access among our members and the communities we serve.
- To support members, customers and providers with COVID-19 vaccination, we are 1) making sure members know there is $0 cost-share for their vaccination through the national public health emergency period, 2) providing resources to help them find COVID-19 vaccine information and 3) providing communications to help encourage vaccination. To help people access COVID-19 vaccination providers, we created the COVID-19 Vaccine Resource Locator. It's available at uhc.com/vaccinelocator. We also encourage members to discuss vaccination with their health care providers.
- UnitedHealthcare is actively monitoring updates from the federal government, Centers for Disease Control and Prevention (CDC), U.S. Food & Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS), as well as state and local public health departments. We're committed to working with federal, state and local organizations to help our members access vaccines and help end the pandemic.
- The FDA has authorized COVID-19 vaccines for emergency use among people age 12 and older, and approved one for use among people age 16 and older. These vaccines are safe and effective at preventing serious illness from COVID-19, according to the CDC. There is 1 one-dose vaccine and 2 two-dose vaccines. The two-dose vaccines require the second dose within 3 to 4 weeks of the first dose. The CDC recommends that people with moderately to severely compromised immune systems receive an additional dose of mRNA COVID-19 vaccine at least 28 days after a second dose of Pfizer-BioNTech COVID-19 vaccine or Moderna COVID-19 vaccine.
- The FDA authorized the use of Comirnaty (Pfizer), Moderna and Johnson and Johnson boosters for individuals 18 and older based on certain criteria. Follow vaccination instructions from the manufacturer.

Additional Vaccine	Ages 12 to 17	Ages 18 to 49	Ages 50 to 64	Ages 65+
3rd Dose Additional dose for immunocompromised population minimum of 28 days after completion of primary series	Immunocompromized • Comirnaty (Pfizer) • Moderna	Immunocompromized • Comirnaty (Pfizer) • Moderna	Immunocompromized • Comirnaty (Pfizer) • Moderna	Immunocompromized • Comirnaty (Pfizer) • Moderna
Booster **Comirnaty (Pfizer)** For immunocompetent population (expected immune system response) minimum of 6 months after completion of primary Pfizer series	Not EUA authorized	• EUA authorized based on individual benefits/risks • EUA authorized for individuals in high risk/exposure professions	• EUA authorized based on health risks • EUA authorized for individuals in high risk/exposure professions	EUA authorized
Booster **Moderna**	Not EUA authorized Submitted for review	• EUA authorized based on individual benefits/risks • EUA authorized for individuals in high risk/exposure professions	• EUA authorized based on health risks • EUA authorized for individuals in high risk/exposure professions	EUA authorized
Booster **Johnson & Johnson**	Not EUA authorized Not submitted for review	• EUA authorized based on individual benefits/risks • EUA authorized for individuals in high risk/exposure professions	• EUA authorized based on health risks • EUA authorized for individuals in high risk/exposure professions	EUA authorized

- COVID-19 infection rates, including those within an entire household, continue to increase. It is recommended by the Centers for Disease Control and Prevention, American Medical Association and the American Academy of Pediatrics that everyone, including those 2 years of age and older, wear a face mask, physically distance and wash hands regularly to reduce the spread of the virus. These organizations also recommend that everyone who can get an FDA-authorized or FDA-approved COVID-19 vaccine should get one. COVID-19 vaccines are critical to helping protect you and your loved ones from serious illness and hospitalization related to the virus.
- In addition to getting the COVID-19 vaccine, prioritizing preventive care is important. We encourage members to stay up to date on their doctor appointments, such as annual checkups and flu vaccines, and get the care they may need for anxiety, depression and loneliness. Most providers also offer telehealth visits, so members can get the care they need outside of the doctor's office.
- There are currently 3 COVID-19 vaccines authorized for emergency use by the FDA. These vaccines are safe and effective at preventing COVID-19, according to the CDC. There is 1 one-dose vaccine and 2 two-dose vaccines. The two-dose vaccines require the second dose within 3 to 4 weeks of the first dose. Follow vaccination instructions from the manufacturer, which will be provided to members by their vaccination provider.
- Once members are fully vaccinated, they can begin to engage in many activities they did before the pandemic, often without wearing face masks or physically distancing. People are considered fully vaccinated after either 2 weeks of receiving the second dose of a two-dose vaccine or after getting the one-dose Janssen vaccine.

  To help protect fully-vaccinated members and others from the COVID-19, including the Delta variant, the CDC and American Medical Association recommend the following:

  - Wear a mask in public indoor places and crowded outdoor spaces in areas with substantial or high COVID-19 infection rates.
  - Wear a mask and follow other public health safety guidelines if you or someone in your household is unvaccinated, has a weakened immune system or has an underlying medical condition.

- Wear a mask in all indoor schools, regardless of vaccination status.
- Wear a mask for 14 days, or until you receive a fully negative test result, when in public indoor settings if you were exposed to someone who might have a COVID-19 infection; the first COVID-19 test should be taken between day 3 and 5 after exposure.

Continue to follow any mask-wearing requirements based on state, local or business guidance. Refer to the CDC guidance for complete public health safety guidance.

- In addition to getting the COVID-19 vaccine, prioritizing preventive care is important. We encourage members to stay up to date on their doctor appointments, such as annual checkups, and get the care they may need for anxiety, depression and loneliness. Most providers also offer telehealth visits, so members can get the care they need outside of the doctor's office.
- Members will have $0 cost-share (copayment, coinsurance or deductible) on COVID-19 vaccinations, no matter where they get the vaccine and including when 2 doses are required, as outlined below:
- Plans through Employers and Individual health plans, including Student Resources, Short Term Limited Liability and Exchange plans, members will have $0 cost-share for the vaccine at both in- and out-of-network providers through the national public health emergency period.
- For Medicare health plans, members will have $0 cost-share for the vaccine at both in- and out-of-network providers through Dec. 31, 2021. Providers should not ask Medicare members for vaccine payment upfront or after the vaccine is received.
- For Medicaid individuals in UnitedHealthcare Community Plans, members will have $0 cost-share for the vaccine at both in- and out-of-network providers through the national public health emergency period. State variations and regulations may apply during this time. Please review the UnitedHealthcare Community Plan website and the state's site for the latest information. If no state-specific guidance is available, UnitedHealthcare plan guidelines will apply.
- If members receive additional services during their vaccination appointment, they may be responsible for copays, deductibles, coinsurance or out-of-network charges, according to their benefits plan. If a member receives a vaccination bill and has questions, they can call the number on their UnitedHealthcare card.
- Once members get their COVID-19 vaccinations, they should keep their COVID-19 vaccination card in a safe place. Members may want to consider taking a picture or scan of the vaccination card as a backup copy. Members may also have a digital vaccination record available through their online UnitedHealthcare member account. We encourage members to keep their health care provider informed of their COVID-19 vaccination.

Frequently asked questions

The CDC remains the best source for COVID-19 vaccine education. UnitedHealthcare will provide helpful information to our members digitally and through our call centers. Members should monitor updates from the local news, health departments, pharmacies and health care providers, who may have more specific information and resources on local vaccine availability.

There are multiple sections of frequently asked questions (FAQs) to help guide people to the right content:

1. Protection and safety
2. Distribution and availability

3. First dose appointment preparation
4. Getting the second dose
5. Cost and coverage
6. Additional resources

General Commonly Asked Questions
Protection and safety

Will the COVID-19 vaccines provide protection from COVID-19? Update 9/7/21

The FDA has approved the COVID-19 vaccine for use in preventing serious illness from COVID-19 among people ages 16 and older. COVID-19 vaccines are also emergency-use authorized (EUA), among people age 12 and older to help prevent serious illness from COVID-19, by the FDA. For people who have certain immunocompromised conditions, the FDA authorized an extra dose of the two-dose COVID-19 vaccines to help maximize protection for this population. Details can be found in the chart below.

COVID-19 vaccines

Vaccine manufacturer	Doses[1]	Ages[2]	FDA Information Statements and Fact Sheets
Comirnaty from Pfizer-BioNTech	2 doses*, 21 days apart	• EUA for 12- to 15-year-olds • EUA for certain immunocompromised people* • Approved for age 16 and older	• Comirnaty for health care providers • Comirnaty for patients and caregivers
Moderna	2-doses*, 1 month apart	• EUA for age 18 and older • EUA for certain immunocompromised people*	• Moderna for health care providers • Moderna for patients and caregivers
Johnson & Johnson's Janssen	1 dose	• EUA for age 18 and older	• Janssen for health care providers • Janssen for patients and caregivers

1 Always follow vaccination instructions from the manufacturer.
2 Available COVID-19 vaccines have received both emergency use authorization and approval from the FDA.
*The CDC recommends that people with moderately to severely compromised immune systems receive an additional dose of the FDA-authorized mRNA COVID-19 vaccine, at least 28 days after a second dose of FDA-authorized Comirnaty COVID-19 Vaccine or Moderna COVID-19 Vaccine.

Like the flu vaccine, vaccination providers will administer the COVID-19 vaccine based on availability. Vaccination providers may not have all FDA-authorized and FDA-approved COVID-19 vaccines at their location.

Important reminders on the protection COVID-19 vaccines provide:

- Like other vaccines, COVID-19 vaccines can take several weeks after vaccination

completion for full effectiveness.
- Fully vaccinated people may carry the virus after exposure, even if they are not showing symptoms. Masks used in indoor and public places help prevent exposure.
- The duration of protection against COVID-19 is currently unknown and being studied.

Because of this, members should follow public health safety guidelines to help protect themselves and others. For the latest information, go to the CDC.

Is the Janssen COVID-19 vaccine effective? Update 5/17/21

All FDA-authorized COVID-19 vaccines are safe and effective at preventing COVID-19, according to the CDC. If you have questions about which vaccine might be right for you, talk to your primary care provider or other health care professional.

What can you tell me about Johnson & Johnson's Janssen COVID-19 vaccine and its safety? Update 5/17/21

The use of Johnson & Johnson's Janssen COVID-19 vaccine has resumed. Medical and scientific teams with the FDA and CDC did a thorough review that found this vaccine is safe and effective in preventing COVID-19. The Janssen COVID-19 vaccine fact sheets for health care providers and patients have been updated to include information about this very rare and serious type of blood clot. Women younger than 50 years old should be aware of this rare risk of blood clots with low platelets after vaccination. Other COVID-19 vaccines, such as Pfizer and Moderna, are available for which this risk has not been seen.

The safety of vaccines is a top priority, and millions of people have already been safely vaccinated. The CDC states this potential safety issue was caught early and reflects the vaccine safety system is working. The brief pause reflected the federal government's commitment to transparency as the CDC and FDA reviewed data. COVID-19 vaccines have undergone, and will continue to undergo, intensive safety monitoring

Learn more about the Janssen COVID-19 vaccine on the CDC website.

Are COVID-19 vaccines safe? Update 5/17/21

All FDA-authorized COVID-19 vaccines are safe and effective at preventing COVID-19, according to the CDC. They are key to slowing the pandemic. The U.S. vaccine safety system makes sure all vaccines go through an extensive process to confirm levels of safety, including the recently FDA-authorized COVID-19 vaccines. Even after emergency use authorization (EUA), the FDA continues to review clinical data about the vaccines. The CDC website has additional COVID-19 vaccine safety information.

Are there side effects associated with COVID-19 vaccines? Update 5/17/21

As with other vaccines, and according to the CDC, people report some side effects with the FDA-authorized COVID-19 vaccines. The most common side effect is a sore arm. Some other side effects may feel like flu and might even affect members' ability to do daily activities, but they should go away in a few days.

If members have side effects that bother them or do not go away, they should report them to their vaccination provider or primary care provider. They should also notify the CDC at 1-800-822-7967, as the CDC and FDA continue to monitor the safety of the FDA-authorized COVID-19 vaccines. Members can also use the CDC's v-safe mobile app, which will help them monitor side effects and get second dose reminders.

What is an emergency use authorization? Update 5/17/21

The FDA has a review process for safety and effectiveness that it completes before granting emergency use authorization (EUA) for the general public. Once the FDA authorizes a vaccine for emergency use, the Advisory Committee of Immunization Practices (ACIP) will meet to vote on recommending the vaccine.

When evaluating an EUA, the FDA carefully balances the potential risks and benefits of the products based on the data currently available. During the national public health emergency period, the FDA continues to monitor both the safety and effectiveness of the vaccine.

As more COVID-19 vaccines are authorized for emergency use by the FDA, ACIP will quickly hold public meetings to review all available data about each vaccine and make recommendations for their use in the United States. Learn more about how CDC is making COVID-19 vaccine recommendations.

Are there people who should not get the COVID-19 vaccine? Update 5/17/21

The current FDA-authorized COVID-19 vaccines are not recommended for people with certain conditions or people of certain ages. The current vaccines are authorized for use among the following ages:

- Pfizer is not authorized for people under the age of 12
- Moderna is not authorized for people under the age of 18
- Janssen is not authorized for people under the age of 18

Per the FDA, women younger than 50 years old should be aware of the rare risk of blood clots with low platelets after Janssen vaccination. Other COVID-19 vaccines, such as Pfizer and Moderna, are available for which this risk has not been seen.

There are other special considerations for when it might not be a good time to get the vaccine:

- If a person has recently been exposed to COVID-19, see the CDC guidelines for getting the vaccine
- If a person had monoclonal antibody treatment or received convalescent plasma, the CDC states vaccination should not occur for at least 90 days

Members should talk to their health care provider if they have questions about getting vaccinated for COVID-19.

According to the CDC, if people have ever had a severe allergic reaction to a vaccine or an injected medicine, they should ask their doctor if they should get the COVID-19 vaccine. A severe reaction is one that requires treatment at a hospital or with medications like an EpiPen (epinephrine). According to the CDC, the likelihood of severe reaction to the FDA-authorized COVID-19 vaccines is very low.

The CDC recommends people who have seasonal allergies or allergies to food, pets or oral medications, can still be vaccinated. If members have questions, they should check with their health care provider.

For more information, read the FDA's patient fact sheets: Pfizer, Moderna and Johnson & Johnson's Janssen. Health care professionals can also look to the FDA's health care provider fact sheets available for Pfizer, Moderna and Janssen.

Should a member get the vaccine if they are pregnant or considering pregnancy in the future?

If a member is pregnant, they can receive a COVID-19 vaccine. It can help protect the member from severe illness associated with COVID-19. According to the CDC, pregnant people are more likely to get severely ill with COVID-19 than non-pregnant people.

If a member would like to get pregnant later in life, they can get the COVID-19 vaccine. According to the CDC, there is no evidence that this vaccine, or any vaccines, may cause problems trying to get pregnant. Scientists continue to study COVID-19 vaccines carefully, as they do all vaccines.

If a member has questions, a conversation with their health care provider about the COVID-19 vaccine may be helpful.

If a member has had COVID-19, can they get vaccinated? Update 5/17/21

According to the CDC, COVID-19 vaccination should be offered to people regardless of whether they've already had COVID-19 infection. And members do not need an antibody or diagnostic test before or after they are vaccinated to learn if the vaccine worked.

Anyone currently infected with COVID-19 should wait to get vaccinated until after their illness has resolved and after they have met the criteria to discontinue isolation. Additionally, current evidence suggests that reinfection with the virus that causes COVID-19 is uncommon in the 90 days after initial infection. People with a recent infection may delay vaccination until the end of that 90-day period.

What is known about the virus variants and vaccine protection? Update 5/17/21

According to the CDC, experts are continuing to study the variants of the virus that causes COVID-19. Viruses constantly change through mutation, and new variants of a virus are expected to occur over time. There are multiple variants of the virus that cause COVID-19 in the United States, and these variants seem to spread more easily than other variants. An increase in cases of COVID-19 can lead to more hospitalizations and potentially more deaths.

FDA-authorized COVID-19 vaccines help prevent the virus from spreading, which in turn can help decrease the opportunity for virus variants to develop and spread. According to the CDC, COVID-19 vaccines do help protect against variants, and they continue to be closely investigated with more studies underway.

To help protect the member's health, they need to follow public health safety practices: wear face masks, physically distance, wash hands regularly and isolate or quarantine when sick. Visit the CDC website to learn more about the virus variants.

What is known about masks and protecting health? Update 8/4/21

Face masks are effective tools in helping slow the spread of COVID-19, especially for people and households who are not yet vaccinated or have an underlying medical condition, according to the CDC. Masks help keep your respiratory droplets in, while keeping others' droplets out. The American Academy of Pediatricians and the American Medical Association support face masks as a science-based tool in helping prevent and control COVID-19.

Make sure your mask works the best it can, according to the CDC:

- Have two or more layers of washable fabric
- Completely cover your nose and mouth
- Fit snugly against the sides of your face without gaps
- Have a nose wire to prevent air from leaking out of the top of the mask
- Learn more about when to wear a mask on the CDC site.

When do members need to quarantine? Update 5/17/21

Local public health agencies determine quarantine recommendations. According to the CDC, quarantine is used to keep someone who might have been exposed to COVID-19 away from others. Exposure is defined as 15 minutes or more of being within 6 feet of an individual who tested positive or had symptoms within 2 days of exposure. By not going in public or staying home, quarantine helps prevent disease spread before a person knows if they have it.

The CDC has identified 2 groups of people who **do not** need to quarantine when exposed:

- People who are fully vaccinated are no longer required to quarantine following a direct exposure to someone with COVID-19, unless they are experiencing COVID-19 symptoms. Fully vaccinated people are considered those who have had a dose of the one-dose vaccine or both doses of a two-dose vaccine, and 2 weeks have passed to allow for the vaccine to work. There are additional considerations for people who are fully vaccinated and in health care settings.
- People who have recovered from COVID-19 in the past 3 months do not need to quarantine.

Learn more on the CDC website.

When do members need to isolate? Update 5/17/21

According to the CDC, isolation is used to separate people infected with COVID-19 from those who are not infected. People who are in isolation should stay home until it's safe for them to be around others. At home, anyone sick or infected should separate from others, staying in a specific "sick room" and using a separate bathroom if possible. The length of isolation period depends on several factors. Review the CDC's recommendations for when isolation can end based on the situation.

Is there an approved COVID-19 vaccine for children younger than 12? New 9/24/21

Not at this time. Pfizer/BioNTech COVID-19 have indicated that the vaccine for children ages 5 to 11 showed promising results and produced a strong antibody response to the COVID-19 virus. The two doses used in the trial is a smaller dose – approximately 1/3 of the adult dose.

Pfizer has indicated that they will be submitting the results to the FDA for review and apply for an Emergency Use Authorization around the end of September. If authorized by the FDA it may be available later in 2021. For reference, here is a link to the full Pfizer press release.

Section 2: Distribution and availability

What other COVID-19 vaccines are in process? Update 10/27/21

There are several COVID-19 vaccines in late stage clinical development in the U.S. and globally. The following is a high-level status of approvals and timing for the current leading vaccine candidates. As of Dec. 18, 2020, here is what we know:

Vaccine type	Manufacturer	Status of trials	Doses required	Expected FDA authorization review
Messenger RNA	Pfizer-BioNTech	Phase 3 complete	2	FDA Approved Booster authorized for ages 18+ 3rd shot authorized for immunocompromised
Messenger RNA	Moderna	Phase 3 complete	2	Authorized for emergency use Booster authorized for ages 18 3rd shot authorized for immunocompromised
Viral vector	Astra Zeneca	Phase 3 in process	2	Expected 2021
Viral vector	J&J/Jannsen	Phase 3 Complete	1	Authorized for emergency use Booster authorized for ages 18
Protein sub-unit	Novavax	Phase 3 in process	2	Expected 2021
Protein sub-unit	Sanofi/GSK	Phase 1/2 results expected Dec. 2020	2	Expected late 2021 or early 2022

FDA-authorization is pending the status of trials and submission of data for emergency use. For the latest information, visit the FDA website.

Current vaccine information can be found at the FDA emergency preparedness and response site for COVID-19. Additional vaccine information can be found at: CDC COVID-19 Vaccines, CDC COVID-19 Things You Need to Know

Where are COVID-19 vaccines available? Update 5/17/21

FDA-authorized COVID-19 vaccines are widely available at retail pharmacies, doctors' offices, hospitals and federally qualified health centers. Many large retail pharmacies are accepting walk-in patients, and large vaccination events may no longer be requiring appointments.

Find resources about vaccine availability for the member's area →

How is UnitedHealthcare helping members get vaccines? Update 5/17/21

We are committed to keeping member informed on vaccines and encouraging vaccination to help protect their health and the health of others. Members can find the most recent information on uhc.com/covid-19vaccines and through their online UnitedHealthcare member account. To help members receive timely information, we encourage them to sign in to their online member account and review their preferences.

UnitedHealthcare is also committed to health equity and supporting our vulnerable members. We have programs to support people at high-risk, including those with high-risk conditions and people age 65+. Members can learn more by calling the number on their UnitedHealthcare member ID card.

What is UnitedHealthcare doing to support members at high risk? Update 5/17/21

According to the CDC, adults of any age with certain underlying medical conditions are at increased risk for severe illness from the virus that causes COVID-19. Severe illness from COVID-19 is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death. UnitedHealthcare is committed to helping our members at high risk find vaccination providers and get vaccinated.

UnitedHealthcare may offer support in three ways: 1) vaccine encouragement via email or telephone, inclusive of our Vaccine Resource Locator to help them find vaccination providers, 2) notification and clinical support through their care management program, or 3) notification and scheduling support through our customer service advocates. Through these programs, UnitedHealthcare encourages vaccination, helps the member find vaccination providers through our Vaccine Resource Locator and provides transportation or community resources, as appropriate. Transportation support varies across UnitedHealthcare plans. We encourage members to talk to their health care providers about when to get vaccinated for COVID-19.

Will UnitedHealthcare help members schedule a vaccination appointment? Update 5/17/21

Members can also use our Vaccine Resource Locator (uhc.com/vaccinelocator) to find vaccination providers near them. For members age 65+ or in our Dual Complete plans, we have transportation and scheduling programs to support members, helping remove any barriers to vaccination. While we have UnitedHealthcare advocates reaching out, members can call the number on their UnitedHealthcare member ID card to learn more about vaccination appointment scheduling support.

What is UnitedHealthcare doing to remove barriers to access? Update 5/17/21

UnitedHealthcare has specific programs to help remove vaccination barriers to build vaccine confidence and support equitable access among both members and our communities.

- To build vaccine confidence, we are taking an insights-driven approach focused on empathy training, delivering the right messages and supporting the right messengers.

- To support equitable vaccine access, data and analytics help us understand our population health dynamic and help guide our member engagement strategies. This includes focus on the right partners and channels for engagement, as well transportation and scheduling programs to support vaccination among the most vulnerable.
- UnitedHealthcare is also supporting initiatives focused on helping vaccinate the vulnerable and underserved through our STOP COVID-19 program and the health insurance industry's Vaccine Community Connectors pilot initiative.
- Health equity in also at the center of how we do business. Our communications and experiences deliver on digital accessibility, health literacy and multi-lingual communications. Our corporate social responsibility program, Empowering Health, provides grant support to local community organizations to aid in health access among the most vulnerable and under-served populations.

See detailed "Vaccine Confidence and Health Equity Talking Points for more details.

Should members get vaccinated through their doctor? Update 5/17/21

UnitedHealthcare recommends members get the first COVID-19 vaccine that becomes available to them and is recommended by a health care professional.

We also recommend the member keep their doctor informed of their vaccination. The member's UnitedHealthcare digital vaccination record may be one way a member may choose to share their vaccination with their doctor or other health care providers. The UnitedHealthcare digital record is not yet available for all members, as we work with the government and other vaccination providers to help make sure members' COVID-19 vaccination data is complete.

Will members have a choice in COVID-19 vaccine? Update 5/17/21

Like the flu vaccine, vaccination providers will administer the COVID-19 based on availability. Vaccination providers may not have all FDA-authorized COVID-19 vaccines at their location. If members have questions, we encourage them to talk to their health care provider.

Section 3: First dose appointment preparation

What do members need to bring to their vaccine appointment? Update 5/17/21

Members should be prepared to show their photo ID, such as a driver's license, to show proof of identity.

- Medicare plan members:
    - They will need their red, white and blue Medicare card because Medicare is paying for the member's vaccine in 2021. If the member doesn't have their Medicare card, they can find it by logging into their Social Security account. More information on their Medicare card can be found on the CMS site.
    - If the member receives their vaccine at a regular provider visit, they will also need their UnitedHealthcare member ID card.

- For people with non-Medicare health plans, they will need to show their UnitedHealthcare member ID card.

Member should wear their face mask and physically distance at their appointment. Additional information on preparing for their vaccination appointment can be found on the CDC website.

If the COVID-19 vaccine has no cost-share, why do members need to show their health insurance card? Update 5/17/21

For many members, UnitedHealthcare pays a fee to the vaccination provider for the administration of the vaccine. In addition, by providing their health insurance card, the member is helping make sure there is a digital record of their COVID-19 vaccination available through their online UnitedHealthcare member account.

If a member receives additional services during their vaccination appointment or get the vaccination during a regular office visit, they may be responsible for copays, deductibles, coinsurance or out-of-network charges, according to their benefits plan.

What should members expect at their appointment? Update 5/17/21

Here are 3 key points from the CDC for members to keep in mind as they prepare for their vaccination appointment:

1. Members' vaccination providers will likely monitor them after receiving the vaccine. This is in case of a rare allergic reaction. So, members should plan on the vaccination appointment taking some extra time.
2. Members should plan ahead for their second dose by scheduling their second vaccine appointment if possible. Members can also sign up for free text messaging through the CDC's VaxText to a get a reminder about their second dose of the COVID-19 vaccine.
3. Members should receive a vaccination card during their appointment that says which vaccine they received, the date it was received and where it was received. We suggest they keep it in a safe place.

For those receiving a two-dose vaccine, the vaccination card will be updated at the member's second dose appointment. We encourage members to keep their vaccination card with them.

Section 4: Getting the second dose

When should a member plan on getting a second dose of the COVID-19 vaccine?

People will need to get both doses within 3-4 weeks to get the protection indicated by the manufacturer. They should make sure both of the doses received are from the same manufacturer and that the second dose is as close to the recommended timing as possible. Follow the vaccination instructions from the manufacturer:

- Pfizer COVID-19 vaccine: Requires 2 doses, given 3 weeks apart
- Moderna COVID-19 vaccine: Requires 2 doses, given 1 month apart
- Janssen COVID-19 vaccine: Requires no second dose

We strongly encourage members to schedule both doses at the same time to meet these time frames and get protection from COVID-19. The vaccination provider should assist the member with scheduling the second dose when they receive their first dose and help them know when to get the second dose.

They can also sign up for free text messaging through the CDC's VaxText to a get a reminder about their second dose of the COVID-19 vaccine.

What if the member misses getting the second dose of the COVID-19 vaccine? Update 5/17/21

The CDC recommends getting the second dose as close to the recommended timing of 3 to 4 weeks as possible. Follow the vaccination instructions from the manufacturer. If a member misses their second vaccination appointment or are outside the 3- to 4-week timing, they can still get the second dose and they won't need to start over with a first dose. And even if the second dose is late, the second dose will still help them get protection from COVID-19. They should schedule their next appointment with their vaccination provider as soon as they can.

What if the member doesn't remember which COVID-19 vaccine they received? Update 5/17/21

They should have received a vaccination card at their first appointment with information on the COVID-19 vaccine manufacturer, date of their first vaccination and when their second dose is due. If they cannot find that, their vaccination provider can help them know which vaccine they received.

What if the vaccine the member received isn't available for their second dose? Update 5/17/21

The member should talk to their health care provider or COVID-19 vaccination provider. They will help the member determine the best next step to completing the COVID-19 vaccination series.

Section 5: Post vaccination

What if the member experiences side effects? Update 5/17/21

Side effects from vaccines are normal signs that your body is building protection. As with other vaccines and according to the CDC, people have reported some side effects with the FDA-authorized COVID-19 vaccines. The most common side effect is a sore arm. Some other side effects may feel like flu and might even affect your ability to do daily activities. But they should go away in a few days. Members can learn more on the CDC website.

If the member experiences pain or discomfort after their vaccination, they can talk to their doctor about taking over-the-counter medicine, such as ibuprofen or acetaminophen. They can also use a virtual visit to connect with a health care professional to discuss their symptoms.

In the event of an emergency, call 911 or go to the nearest hospital.

If members have side effects that bother them or do not go away, they should report them to their vaccination provider or primary care provider. They should also notify the CDC at 1-800-822-7967. This is because the CDC and FDA continue to monitor the safety of the FDA-authorized COVID-19 vaccines. Members can also use the CDC's v-safe mobile app, which will help them monitor side effects and get second dose reminders.

What if the member experiences side effects from the Johnson & Johnson's Janssen vaccine? Update 5/17/21

According to the CDC, if the member got the Janssen vaccine within the last 3 weeks, their risk of developing a blood clot with low platelets is very low. However, they be on the lookout for possible symptoms of a blood clot with low platelets, which typically occur within 3 weeks of vaccination. Seek medical care urgently if any of these symptoms develop:

- Severe headache
- Backache
- Blurred vision
- Fainting
- Seizures
- Severe pain in your abdomen or stomach
- Severe pain in your chest
- Leg swelling
- Shortness of breath
- Tiny red spots on the skin (petechiae)
- New or easy bruising or bleeding

If you have other questions, call your primary care provider or other health care professional. You can also use a virtual visit to connect with a health care professional. To access 24/7 on-demand virtual visits through a designated national provider, sign in to your online UnitedHealthcare account. Cost-share for the virtual visit will be according to your benefits plan.

Can members stop wearing a mask after they get a COVID-19 vaccine? Update 5/17/21

It depends. If a member has received only one dose of a two-dose vaccine, they should continue to wear a mask, physically distance and wash their hands regularly to protect themselves from COVID-19.

The CDC guidance changes once a person is fully vaccinated, which means it is 2 weeks after they have received the second dose of a two-dose vaccine or after getting the one-dose Janssen vaccine. According to the CDC, fully vaccinated people can resume many activities that they did prior to the pandemic, without wearing a mask or physically distancing. Mask-wearing requirements may vary based on state, local or business guidance.

Learn what you need to know about mask-wearing and choosing safer activities

What should members do with their vaccination card? Update 5/17/21

We encourage members to keep their vaccination card in a safe place. Members may want to consider taking a picture or scan of the vaccination card as a backup copy. Members should not post a picture of their vaccination card on the internet or via social media, as there may be people who try to use the member's information as their own.

The member's digital vaccination record, which may be available through their online UnitedHealthcare member account and mobile app, may also be helpful in situations where a member may need to show proof of vaccination.

Will UnitedHealthcare have a member digital vaccine record? Update 5/17/21

Members may have access to a digital vaccination record within their online UnitedHealthcare member account and the UnitedHealthcare mobile app. The record puts the member's vaccination information at their fingertips, and may be helpful for employment, return to school or doing other activities where a COVID-19 vaccination record may be requested. This digital record is not intended to replace your official CDC COVID-19 Vaccination Record Card.

Beginning in June, members may choose to self-report their vaccination using their digital record within their online UnitedHealthcare member account. UnitedHealthcare may use that information to help members get timely information, including booster shot reminders. Should we receive updated vaccination data from the member's vaccination provider, their self-reported data will be replaced.

We encourage members to keep their doctor informed of their vaccination. The UnitedHealthcare digital vaccination record is one way the member may choose to share their vaccination information with their doctor or other health care provider.

At this time, UnitedHealthcare will not have a COVID-19 vaccination record for all members given the many different vaccination sites and resulting incomplete data. UnitedHealthcare continues to work closely with states and other vaccination providers to help make sure members will have access to a reliable digital record of their vaccination.

See Vaccination Record 2.0 talking points for more details.

Do members need a COVID-19 test after they get vaccinated to make sure it's working? Update 5/17/21

No, the CDC does not recommend people get COVID-19 antibody or diagnostic testing to understand whether a vaccine worked.

If exposed to COVID-19 post-vaccination, do members need to quarantine? Update 5/17/21

According to the CDC, people who are fully vaccinated are not required to quarantine following a direct exposure to someone with COVID-19, unless they are experiencing symptoms. Fully vaccinated people are considered those who have had the one-dose vaccine or both doses of a two-dose vaccine, and a period of 2 weeks has passed to allow for the vaccine to work. There are additional considerations for fully vaccinated patients and residents in health care facility settings.

Section 6: Cost and coverage

Will COVID-19 vaccines be covered at $0 cost-share, including at out-of-network locations? Update 5/17/21

Yes. Members will have $0 cost-share (copayment, coinsurance or deductible) on their COVID-19 vaccination, no matter where they get the vaccine and including when 2 doses are required, as outlined below:

- **Plans through Employers and Individual plans, including Student Resources, Short Term Limited Liability and Exchange plans**: Members will have $0 cost-share for the vaccine at both in- and out-of-network providers through the national public health emergency period. UnitedHealthcare pays a fee to the vaccination provider for the administration of the vaccine and the recommended observation. If the member receives care for an adverse reaction, they may be responsible for copays, deductibles, coinsurance, or out-of-network charges, according to their benefits plan.
- **For Medicare plans**: Members will have $0 cost-share for the vaccine at both in- and out-of-network providers through Dec. 31, 2021. Providers should not ask Medicare members for vaccine payment, upfront or after they receive the vaccine.
- **For Medicaid members in UnitedHealthcare Community Plans**: Members will have $0 cost-share for the vaccine at both in- and out-of-network providers through the national public health emergency period. State variations and regulations may apply during this time. Please review the UnitedHealthcare Community Plan website and state's site for the latest information. If no state-specific guidance is available, UnitedHealthcare plan guidelines will apply.

If a member receives additional services during their vaccination appointment or get the vaccination during a regular office visit, they may be responsible for copays, deductibles, coinsurance or out-of-network charges, according to their benefits plan.

Members should not receive any bills for their COVID-19 vaccination from their provider or UnitedHealthcare during the national emergency health period. The member's vaccination provider should not charge them for the standard observation, which is the 15 to 30 minutes after receiving the vaccination. Members who have questions about their coverage or bills can go to their online UnitedHealthcare account or call the number on their health insurance card.

What if a member gets the vaccine during their office visit? Update 5/17/21

If a COVID-19 vaccine is received during an office visit where members talk about other health needs, they may have a cost-share for the office visit. The office visit will then be covered according to benefits plan. This means the member would be responsible for any copay, coinsurance or deductible, according to their benefits plan. The vaccine will have $0 cost-share for the time periods above.

Should members pay to get their name on a COVID-19 vaccination list? Update 5/17/21

No. Be on alert for fraud. If someone calls, texts, or emails promising access to the vaccine for a fee, personal or financial information should not be shared. Members should not give their credit card, social security number, PayPal® account, Venmo® account or any other payment information to anyone to get access to a COVID-19 vaccine.

- No one should ask a member to pay to put their name on a list to get the vaccine
- No one should ask a member to pay to get early access to a vaccine

UnitedHealthcare will only request secure information from members through their password-protected member account.

In addition, members should avoid fraud by not posting any pictures of their vaccination card on the internet and social media. There are scammers who might try to use that photo for their own.

If a member suspects fraud or is unsure, they have several ways to report it. Visit uhc.com/fraud, to start an online report. Or call one of the following numbers.

- Call the number on the health insurance member ID card
- Call 1-844-359-7736 if they're a UnitedHealthcare member
- Call 1-800-MEDICARE if they're a Medicare member

Members can learn more about how to protect themselves from fraud on uhc.com.

How will providers be reimbursed for COVID-19 vaccines? Update 5/17/21

For COVID-19 vaccine administration billing and reimbursement information, go to uhcprovider.com.

Will UnitedHealthcare support an employer who wishes to increase premium for their employees who are unvaccinated? Update 9/2/21

No. UnitedHealthcare does not increase premium if an employee is not vaccinated.

Section 7: Additional COVID-19 resources

Additional resources for COVID-19 vaccine information are below:

- CDC VaccineFinder: https://vaccinefinder.org/search/
- CDC's When you've been fully vaccinated: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html
- CDC's Things to know about COVID-19 vaccines: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/8-things.html
- Authorized COVID-19 vaccines from the FDA: https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

VACCINE PASS

Does UnitedHealthcare have a vaccine pass for members? New 9/24

Yes. Members can now access their COVID-19 vaccine record on myuhc.com.

Now that proof of COVID-19 vaccinations may be required for some activities in certain locations, UnitedHealthcare is providing vaccinated members with a COVID-19 vaccine record and vaccine pass with QR code. These are additional tools, outside of the COVID-19 Vaccination Card from the Centers for Disease Control and Prevention (CDC), to help members more conveniently show proof of vaccination while on the go.

Members can print and share their UnitedHealthcare vaccine record by accessing their account on myuhc.com or medicare.uhc.com. Most members will notice that UnitedHealthcare has automatically updated their vaccine record based on vaccination data received through UnitedHealthcare records, including claims and information from federal and state agencies, as well as vaccination providers. If members do not see their COVID-19 vaccination information in their account, they can update their records by uploading proof of vaccination (I.e., CDC vaccination card) while logged in to their account.

In addition, some members may be able to activate a vaccine pass with a QR code – available for printing or sharing digitally and can be read by most QR readers to digitally confirm a member's vaccination status.

The UnitedHealthcare vaccine pass leverages technology from the Vaccination Credential Initiative. This COVID-19 vaccine record and the COVID-19 vaccine pass with QR code are currently available to UnitedHealthcare Commercial, Medicare Advantage, Group Retiree and Part D health plans.

COVID-19 vaccination records are located in the members' secure account at myuhc.com or medicare.uhc.com. The UnitedHealthcare mobile app also includes a health record and will be updated to include the vaccine pass in late October.

VACCINE CLAIM, BILLING AND REPORTING

How will providers be reimbursed for COVID-19 vaccines? New 3/1/21

For COVID-19 vaccine administration billing and reimbursement information, go to uhcprovider.com.

How will participating providers and pharmacist bill vaccine administration? New 12/10

Participating providers may bill the UnitedHealthcare medical benefit through our standard claims process.
Pharmacist should submit to their claim pharmacy platform. Rates will be paid at the CMS defined reimbursement levels. State Medicaid may provide different guidance.

If an out-of-network provider bills above the CMS published rates for the administration of the vaccine, the member will not be held liable for payment of the administration service. Per federal

provisions, a health care provider may not balance bill or impose cost share on a member for the cost of a vaccine or the administration. This applies for both in- and out-of-network providers.

What is the COVID-19 vaccine cost to customers? Update 10/17/21

The COVID-19 vaccine serum will initially be paid by the government. For Employer and Individual* health plans, UnitedHealthcare and self-funded customers will be required to cover the administration of COVID-19 vaccines with no cost-share for in- and out-of-network providers, during the national public health emergency period. Administration fees for in-network providers will be based on contracted rates. Administration fees for out-of-network providers will be based on CMS published rates as noted below.

- Administration fees for in-network providers will be based on contract rates. Like CMS admin published rates with some variance higher or lower due to contracted rates.
- Administration fees for out-of-network providers will be based on CMS published rates
- Administration fees for vaccines in a pharmacy is based on the new CMS rate of $40 per dose that began March 15, 2022.

For COVID-19 vaccine administration billing and reimbursement information, go to uhcprovider.com.

What is the member and plan sponsor cost share? New 12/10

The COVID-19 vaccine serum will initially be paid by the government. Eligible members receiving the vaccine will not have any out-of-pocket costs.

For Employer and Individual health plans, UnitedHealthcare and self-funded customers will be required to cover the administration of COVID-19 vaccines with no cost share for in- and out-of-network providers, during the national public health emergency period. Administration fees for in-network providers will be based on contracted rates. Administration fees for out-of-network providers will be based on CMS published rates.

What is UnitedHealthcare approach for medical claims? Update 2/26/2021

UnitedHealthcare aligns with America Medical Association (AMA) CPT coding for medical claims. Health care professionals should use published AMA CPT codes when submitting COVID-19 vaccine and vaccine administration claims to UnitedHealthcare under the medical benefit.

Currently approved AMA CPT Codes:

Manufacturer	Vaccine Dose CPT	National Drug Code	1st Administration CPT	2nd Administration CPT
Pfizer	91300	59267-1000-1	0001A	0002A
Moderna	91301	80777-273-10	0011A	0012A
Johnson and Johnson*	91303		0031A	N/A
AstraZeneca*	91302	00310-1222-10	0021A	0022A

- Not yet approved or available

Additional codes will be added as they become available.

Codes will be added to all applicable provider fee schedules as part of the standard quarterly code update and any negotiated discounts and premiums will apply to these codes. Codes will be added using the CMS published effective date for the codes and payment allowance as the primary fees source.

Modifiers

Modifiers are not required when submitting administration COVID-19 vaccine or vaccine claims through medical.

What is UnitedHealthcare approach for pharmacy claims and administrative costs? New 12/10

Pharmacies will be allowed to bill UnitedHealthcare directly for the costs associated with the administration of COVID-19 vaccines. Pharmacists administering the COVID-19 vaccine serum provided by the federal government should submit claims through their pharmacy claims platform. Claims for Medicare Advantage members should be billed to the applicable CMS Medicare Administrative Contractor (MAC).

National Council for Prescription Drug Programs (NCPDP) has designated two submission clarification codes (SCC) for pharmacy billing as the differentiating value for the dose currently being administered. OptumRx® is updating its claims system to allow different reimbursement rates based on the submitted SCC and professional service code value from the pharmacy:

SCC/PSC Value	Description
SCC 2	Indicates initial dose
SCC 6	Indicates that the previous medication was a starter dose and additional medication is needed to continue treatment
"MA" (Medication Administered)	Indicates that pharmacies can submit claims with a DUR PPS code = MA to trigger an administration fee

Additional information on billing pharmacy claims can be found in the NCPDP Emergency Preparedness Guidance –COVID-19 Vaccines guide.

What is UnitedHealthcare reporting for COVID-19 vaccines? New 1/15/2021

COVID-19 vaccine analytics for UnitedHealthcare customers is available on the current self-service COVID-19 Claim Summary Report. This report site is expanding to include a section reflecting the number of members who are partially and fully vaccinated. For questions contact your UnitedHealthcare representative.

Will UnitedHealthcare cover services for the treatment of side effects from the COVID-19 vaccine? New 2/25/2021

Although mild to moderate adverse effects are relatively common following vaccine administration, side effects requiring medical treatment are rare. In the event a vaccine side effect does require a patient to seek medical care, those services will be covered according to their benefit plan. Standard member cost sharing will apply.

Are there diagnosis codes used to indicated that services are related to an adverse reaction to the COVID-19 vaccine? New 2/25/2021

There are not specific codes to use for treatment claims for patients with COVID-19 side effects. Claims should be billed to reflect the appropriate symptoms and services provided.

ADDITIONAL RESOURCES

Where can we get additional information? Update 3/1/2021

- CDC Vaccine Finder: https://vaccinefinder.org/search/
- 8 things to know about COVID-19 vaccines from the CDC
- Authorized COVID-19 vaccines from the FDA
- COVID-19 vaccine myths debunked
- FDA COVID-19 Vaccines

- UnitedHealthcare COVID-19 Member Resource Center - Health care professionals, partners, customers and members can expect timely UnitedHealthcare communications on uhc.com, members' online UnitedHealthcare accounts and uhcprovider.com regarding COVID-19 vaccine access, coverage and cost.
- 8 things to know about COVID-19 vaccines from the CDC
- Authorized COVID-19 vaccines from the FDA
- COVID-19 vaccine myths debunked
- CDC COVID-19 Vaccines
- FDA COVID-19 Vaccines
- COVID-19 vaccine myths debunked from the Mayo Clinic: https://www.mayoclinichealthsystem.org/hometown-health/featured-topic/covid-19-vaccine-myths-debunked?fbclid=IwAR3z-ddtLMoRDJlFVJrVjdiA1qGNMvZaoulvBjaTjZFLce8KzfjVaM3bux4
- Pharmacies participating in the COVID-19 vaccination program: https://www.cdc.gov/vaccines/covid-19/long-term-care/pharmacy-partnerships.html

Vaccine Billing Resources for providers

- CMS Enrollment for Administering COVID-19 Vaccine Shots
- CMS Medicare Billing for COVID-19 Vaccine Shot Administration
- CMS Coding for COVID-19 Vaccine Shots
- CMS COVID-19 Vaccine Shot Payment
- Roster Billing Guidance
- UnitedHealthcare COVID-19 Vaccine Guidance

MEMBER SUPPORT

What is UnitedHealth Group doing to help members concerned with COVID-19?

UnitedHealthcare has a team closely monitoring COVID-19, formerly known as the Novel Coronavirus or 2019-nCoV. Our top priority is the health and well-being of the people we serve.

As with any public health issue, UnitedHealthcare will work with and follow all guidance and protocols issued by the U.S. Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and state and local public health departments.

How can people access Sanvello free if they are impacted by COVID-19? Update 6/2

Sanvello Health, Inc., a leading provider of digital and telephonic mental health solutions to individuals, businesses and payers will be providing free premium access to its digital care delivery platform.

This offer makes Sanvello's clinically validated techniques, coping tools and peer support free for the duration of the crisis to anyone impacted by COVID-19.

To activate free premium access, anyone can download Sanvello for free from the App Store or Google Play and create an account to begin using the strategies, tools, and peer support. Services are free through June 30, 2020.

In order to maintain free access to Sanvello premium after June 30, 2020, eligible UnitedHealthcare members must register using their UnitedHealthcare medical insurance card. Eligible members who have not registered using their insurance information will need to adjust their account appropriately to maintain free access to Sanvello.

Are there tools to help people understand their symptoms or find a testing site near them? New 4/6

Yes, UnitedHealthcare is committed to helping people protect their health by expanding access to care, support and resources during this unprecedented time. By going to the myuhc.com pre login website people may use the online symptom checker to assess their risk for COVID-19 and get treatment options.

The Test Location tool helps individuals find a COVID-19 diagnostic test location in their area. In most test locations they will ask for a script from a provider. Use the telehealth option to contact a provider for a script.

For members, by signing in to myuhc.com there are additional resources and care information access to member benefits.

Are there any plans to enhance the support materials available on liveandworkwell related to this crisis?

Yes - a COVID-19 portal went live on the liveandworkwell website on March 18.

If an individual is tested and the provider rules out COVID-19, does the employee need any documentation that they can provide their employer for return to work clearance?

This is a policy determined between the employer and employee.

Considering the current situation, is UnitedHealthcare delaying member communications related to preventive campaigns?

Yes. UnitedHealthcare will temporarily delay certain preventive care reminders.

Certain *HealtheNotes* and *HealtheNote Reminders* to members have been paused for April since many of these messages direct members to seek care for services that would be considered non-emergent in this COVID-19 era.

Does the CDC recommend getting a flu shot? New 9/14

It's more important than ever this year with COVID-19. COVID-19 and the flu will both be spreading this season, according to the Centers for Disease Control and Prevention (CDC).

Protecting yourself from the flu helps reduce your risk of hospitalization. Many hospitals and ICUs may have reduced availability due to COVID-19.

It is recommended for most people including everyone 6 months and older, even healthy people. It is especially important for adults 65 and older, pregnant women, young children under 2 years old, and people with certain health conditions. Many high-risk people would also benefit from a pneumonia vaccine.

The flu vaccine can help weaken or prevent the flu and the vaccine is covered a 100% for UnitedHealthcare members. Generally, it is recommended to get the flu shot by the end of October according to the CDC, especially with the ongoing spread of COVID-19. Discuss the flu and other vaccines and the best timing with your provider. Plan ahead to get a flu shot. Talk to your health care provider or find a flu shot location here.

Are there other precautions as flu and COVID-19 spread this fall and winter? New 9/14

Careful actions, like handwashing, mask-wearing and keeping a safe distance in public spaces, can help protect you and your community.

Actions that people should take:

- If you're feeling sick, stay home
- Wash your hands throughout the day, especially after you've been in a public place or if you sneeze or cough
- Avoid close contact with others and maintain a physical distance from others when you're in public spaces.
- Wear a cloth mask to cover your mouth and nose when you're around others. This helps protect others in case you may be infected.
- Clean and disinfect frequently touched surfaces daily

- For more healthy habits, visit the CDC

COBRA

Is UnitedHealthcare able to offer help to employees who are losing their health insurance coverage after being laid off? Update 3/8/2021

In general, under COBRA, an individual who was covered under a group health plan on the day before a qualifying event, such as being laid off or a reduction in hours leading to a loss of coverage, may be able to elect continue coverage. UnitedHealthcare administers COBRA on behalf of customers with group health plans, which includes providing covered employees and their families with certain notices explaining their COBRA rights. UnitedHealthcare also offers individuals a range of individual health insurance plans. Interested individuals may contact (800) 827-9990 to speak with an advisor who can assist.

They can also visit https://www.healthmarkets.com to apply directly.

If a person does not qualify for COBRA, what are their alternatives? New 6/6

UnitedHealthcare offers individuals a range of individual health insurance plans. Interested individuals may contact (800) 827-9990 to speak with an advisor who can assist. Or, they can also visit https://www.healthmarkets.com to apply directly.

Individuals may be able to get health care coverage through the Health Insurance Marketplace. It may also cost less than COBRA continuation coverage. There are special enrollment periods available if their job situation has resulted in lost your coverage.

An individual may compare costs to see if a short-term insurance plan would work for their needs. Standard short term health insurance plans may help fill a gap in coverage from 1 month to just under a year.

Through the Health Insurance Marketplace you can also check if you may qualify for free or low-cost health care coverage from Medicaid or the Children's Health Insurance Program (CHIP)

How does COBRA coverage work? New 4/4

COBRA is a short-term insurance that's usually available for up to 18 months after a person's job situation has changed. (In some situations, COBRA coverage may extend beyond 18 months).

Generally, a person can get COBRA coverage if they worked for a business that employs 20 people or more. There are exceptions to this, so the person should confirm with the employer.

With COBRA, persons can continue the same coverage they had when they were employed. That includes medical, dental and vision plans. They cannot choose new coverage or change plans to a different one. For example, if a person had a medical plan and a dental plan, they can keep one or both. But they wouldn't be able to add a vision plan if it wasn't part of the plan they had before COBRA.

When a job situation has changed, can the impacted member get health insurance through COBRA? Update 3/8/2021

A person may qualify for COBRA coverage if their job situation has changed in one of these ways:

- They lost their job, either voluntarily or by the decision of the company (for any reason except gross misconduct) and they lost health coverage
- They had the number of hours per week they worked reduced, so they no longer were eligible for benefits and lost their health coverage
- Individuals who have the right to elect to continue coverage are known as Qualified Beneficiaries (QBs)

Currently, a QB (must be given at least 60 days to elect to continue coverage after job loss or a reduction in hours of employment that leads to a loss in coverage. The QB must pay their first COBRA premium with 45 days of making the election. After that, monthly payments must be made within 30 days of the start of the coverage month.

Under Disaster Relief Notice 2021 01 issued in response to the COVID National Emergency, the timeframe has changed. Timeframes are determined by referring to the end of Outbreak Period (the end of the National Emergency plus 60 days) or one year. This means:

- the timeframe for the election of coverage is suspended until the earlier of 60 days from the end of the Outbreak Period or one year from the COBRA qualifying event, plus any remaining time from the normal election period.
- the timeframe for making the initial COBRA premium payment is suspended until the earlier of 45 days from the end of the Outbreak Period or one year from the due date for the initial payment, plus any time remaining from the normal initial payment deadline.
- the timeframe for making a monthly COBRA payment is suspended until the earlier of 30 days from the end of the Outbreak Period or one year from the payment due date, plus any time remaining from the monthly payment deadline.

The QB must elect COBRA coverage and make the required premium payment as outlined in their Qualifying Event Notice communication for coverage to be activated and claims to be paid. It is important the QBs understand that coverage will not be activated, and claims will not be processed, until the required premium is paid. If a QB does not make required premium payments timely, claims will not be paid until the premium payments are made.

Once the suspension of timeframes is over, the standard timeline will be:

- COBRA elections must be made with 60 days.
- Initial COBRA payments must be made within 45 days of the COBRA election, and
- Monthly COBRA payments must be made within 30 days of the monthly payment deadline.

What's covered under COBRA? New 5/29

With COBRA, a person can continue the same coverage they had when they were employed. That includes medical, dental and vision plans. They cannot choose new coverage or change their plan to

a different one. For example, if they had a medical plan and a dental plan, they can keep one or both. But they wouldn't be able to add a vision plan if it wasn't part of their plan before COBRA

How can a person get health insurance if they don't qualify for COBRA? Update 3/8/2021

They may be able to get coverage through the Health Insurance Marketplace, which may cost less than COBRA continuation coverage, particularly when subsidies are available through the Marketplace. There are also special enrollment periods available when job loss or a reduction in hours results in a loss of coverage. The COBRA participant may also have special HIPAA enrollment rights under their spouse's plan if they had coverage under their employer's plan at the time their spouse enrolled in their other coverage. Individuals over age 65 may find that they do not have to pay for COBRA because they are eligible for Medicare.

You can compare costs to see if a short-term insurance plan would work for your needs. Standard short term health insurance plans may help you fill a gap in coverage from 1 month to just under a year.

Through the Marketplace they may qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Does UnitedHealthcare offer individual health coverage options for members who have been laid off or deactivated by their employers? New 5/1

Yes. Members in this situation may have individual coverage options available besides COBRA, including ACA Exchange plans, Medicare plans for those over 65, Medicaid plans for those that qualify based on income level, short term limited duration insurance plans and more.

Broker information and resources to help customers connect laid off/termed employees to individual coverage options.

The employer or member may contact their broker or call the **toll-free hotline at 1-844-316-8479 and** speak to a licensed insurance agent who can conduct a comprehensive needs analysis and help an them find the coverage solutions that may be right for them based on their specific needs.

Customizable information and support:

Individual Coverage Options Email — Send to employees following layoff or termination.

Employee Letter: Introduces Individual Coverage Options — Attach to email (above) or send via mail to employees following layoff or termination.

Individual Coverage Options Flier — Attach to email or include with letter.

If an employee declined COBRA coverage in the last 30 days, does this re-open their ability to elect? New 4/5

If a COBRA eligible member declined COBRA coverage, they will no longer be eligible. They would need to consider one of the options available for individuals, such as the Health Insurance Marketplace or a short-term duration policy.

How do I pay for COBRA? Update 3/8/2021

Under COBRA individual are required to pay the full premium for coverage, plus a 2% administrative fee. When employed, the employer generally pays for some of the cost of your health insurance. That means individuals are likely to pay more for COBRA coverage.

Learn more about COBRA coverage

Are members able to just pay for those months of COBRA continuation that they need as opposed to making all the required payments? How about if the member is stuck overseas due to COVID? Update 3/8/2021

No. While nothing would require an individual to pay the entire year's COBRA premium, members are not allowed to select the months of COBRA they want to pay for.

If a member is laid off, they can elect COBRA due to termination? If a member is furloughed, can they elect COBRA? Update 3/8/2021

They might not be eligible for COBRA if they lose their job or are furloughed if they are still able to obtain group health plan benefits through their employer. If the employer decided to discontinue offering medical benefits to their laid off or furloughed employees, then COBRA may be a coverage option.

In other words, if benefits are offered during furlough, COBRA is not an option. However, if the employer does not offer benefits to the furloughed employees, COBRA would be an option.

What does the recent guidance state on extension of COBRA notices and elections? Update 3/8/2021

Under Disaster Relief Notice 2021 01 issued in response to the COVID National Emergency, the timeframe for electing COBRA has changed. Timeframes are determined by referring to the end of Outbreak Period (the end of the National Emergency plus 60 days) or one year. This means:

- the timeframe for the election of coverage is suspended until the earlier of 60 days from the end of the Outbreak Period or one year from the COBRA qualifying event, plus any remaining time from the normal election period.
- the timeframe for making the initial COBRA premium payment is suspended until the earlier of 45 days from the end of the Outbreak Period or one year from the due date for the initial payment, plus any time remaining from the normal initial payment deadline.
- the timeframe for making a monthly COBRA payment is suspended until the earlier of 30 days from the end of the Outbreak Period or one year from the payment due date, plus any time remaining from the monthly payment deadline.

The QB must elect COBRA coverage and make the required premium payment as outlined in their Qualifying Event Notice communication for coverage to be activated and claims to be paid. It is important that QBs understand that coverage will not be activated, and claims will not be processed, until the required premium is paid. If a QB does not make required premium payments timely, claims will not be paid until the premium payments are made.

Once the suspension of timeframes is over, the standard timeline will be:

- COBRA elections must be made with 60 days.
- Initial COBRA payments must be made within 45 days of the COBRA election, and
- Monthly COBRA payments must be made within 30 days of the monthly payment deadline.

How are COBRA participants notified of the temporary extension? Update 8/12

A COBRA Reinstatement notice was mailed In May to the 700 individuals whose coverage was deactivated for nonpayment before the rule came out.

How does the revised COBRA timeline work during the COVID-19 Outbreak Period? Update 3/8/2021

- With the changed timelines, the election period is extended the earlier or 60 days following the end of the Outbreak Period or a maximum of one year after the COBRA qualifying event, plus any time remaining on the normal election period. The participant may elect to continue coverage any time during the Outbreak Period and must pay their premium for coverage to be activated and claims to be processed.
- A statement for premiums is mailed each month. For claims to be processed, the participant must make the initial and monthly required payments.
- the timeframe for making the initial COBRA premium payment is suspended until the earlier of 45 days from the end of the Outbreak Period or one year from the due date for the initial payment, plus any time remaining from the normal initial payment deadline.
- the timeframe for making a monthly COBRA payment is suspended until the earlier of 30 days from the end of the Outbreak Period or one year from the payment due date, plus any time remaining from the monthly payment deadline.

Does the Disaster Relief Notice 2021-01 apply to Mini COBRA and State continuation coverage? Update 3/8/2021

The notice does not apply to Mini COBRA or State Continuation.

Is the 18 month COBRA coverage period impacted by this order? Does the Outbreak Period extend the 18 months? New 5/14

The COBRA coverage period is not impacted by this notice.

Does Disaster Relief Notice 2021-01 apply to Ancillary products? Update 3/8/2021

All products subject to COBRA, such as medical, dental and vision benefits would have timeframes for elections and payment suspended.

Does Disaster Relief Notice 2021 01 apply to both fully insured and self-funded plans? Update 3/8/2021

Yes. The changes apply to fully insured and self-funded products.

If I elect COBRA coverage, will my policy be effective even if I don't make a payment? Update 3/8/2021

A participant may activate COBRA coverage by making the required payment in full by the earlier of 30 days after the end of the outbreak period or a maximum of one year from the COBRA qualifying event, plus any time remining under the premium payment deadline. Otherwise, claims will be the responsibility of the individual.

How will we officially know when the Outbreak Period ends? Update 3/8/2021

The National Emergency ends when the President revokes or does not extend the order. The president extended the National Emergency on February 24, 2021 for up to one year. We are monitoring the situation and will communicate the change.

Will we need to notify COBRA participants of the date the Outbreak Period ends? Update 3/8/2021

COBRA requires that administrators notify QBs when continuation coverage is no longer available. We do expect that COBRA will no longer be available to QBs after the National Emergency ends, 60 days expire and additional time remaining on applicable timeframes is exhausted.

How will UnitedHealthcare communicate the new timeframes to employers? Update 3/8/2021

We will leverage the FAQ information on uhc.com/employer and through article posted on uhc.com customer news section.

What is UnitedHealthcare's normal grace period for Cobra payments Update 3/8/2021

Once the initial payment has been made within 45 days of the election, the normal grace period for premium payment is 30 days after the monthly due date.

If a participant does not make required payments during Outbreak Period, coverage will not be activated. Under the Notice, the timeframe for the employee (or qualified beneficiary) to make their required payments has been extended. However, if premiums remain unpaid, claims will be the responsibility of the individual.

What is UnitedHealthcare's normal policy for individuals to give notice of a qualifying event? Update 3/8/2021

Currently, a covered employee (or one of the qualified beneficiaries) must be allowed at least 60 days to give notice to a Plan that certain qualifying events have occurred. These events include divorce, legal separation or loss of child dependent status. Employers, on the other hand, have 30 days to give notice of a qualifying event that includes termination or reduction in hours of employment, death of the employee, entitlement to Medicare or an employer bankruptcy. Once notice of a qualifying event is given, the Plan has 14 days to issue the COBRA election notice.

Under the final rule, the timeframe for the employee (or qualified beneficiary) to give notice to the Plan has been extended to the earlier of at least 60 days after the end of the Outbreak Period or a maximum of one year from the employee becoming eligible for COBRA, plus any time remaining to give notice under the normal rules.

Can you confirm what will happen from a claim standpoint if a COBRA member has not paid premium, are we still required to pay claims? Update 3/8/2021

If a COBRA member has not paid premium, coverage will not be activated, and claims will not be processed. The individual has until the earlier of 30 days after the end of the Outbreak Period or one year of their premium due date, plus any time remaining under the payment rules to make the payment.

Can a COBRA member be reinstated if the individual makes the required payments to their employer after being deactivated? New 9/18

Yes. The member will be reinstated, and claims processed back to the last paid through date beginning on or after 3/1/2020. Once the President announces an end date to the Outbreak Period, the member has until 30 days after the Outbreak Period ends to make the required COBRA premium payment.

With the new regulations allowing COBRA participants to miss making payments and still be able to stay on the plan, if a customer provides a report, can UnitedHealthcare not activate those beneficiaries whose accounts are in arrears, but not terminate them? Update 3/8/2021

Yes. Our approach is to deactivate coverage when the required premium is not paid. However, coverage may be reactivated if the premium is paid prior to the earlier of 30 days after the end of the Outbreak Period or within one year of the individual's eligibility plus any remaining time under the normal rules. When required premiums are made timely, UnitedHealthcare will process claims.

Are employer groups required to continue to make COBRA premium payments they are billed for, even if COBRA beneficiaries have not paid the group for their COBRA premium? Update 3/8/2021

No. Groups are not responsible for the COBRA premium. Under the Notice, the plan can require that all the premium be paid the earlier of 30 days of the end of the Outbreak Period or within one year from the COBRA qualifying event plus any remaining time to make payment under the normal rules.

If an employer group paid UnitedHealthcare on behalf of a COBRA member without receiving the required payment from the COBRA member, can the employer group recoup that payment upon deactivation of that COBRA member? Update 10/1

The Department of Labor COVID19 Payment Extension Final Rule, has been updated based on interpretation from the IRS that allows for deactivation with re-instatement if premiums are paid.

Our policy is that we would retroactively deactivate the member's coverage back to the date of the COBRA qualifying event. The customer would receive a credit on its invoice.

How would UnitedHealthcare handle the situation for an employer who has been paying COBRA premium, but the former employee has not paid their premium or stopped paying premiums?
Update 2/15/2015

The Department of Labor COVID19 Payment Extension Final Rule allows for deactivation of coverage with re-instatement if premiums are paid. Based on this guidance, Groups/COBRA Administrators are permitted to deactivate coverage for non-payment. A revised process to handle these retro deactivations is being implemented, which will allow customers to retroactively deactivate COBRA members back to the last pay thru date (back to 3/1/2020) without going through the RMS process.

- If payment has been made by the employer for the COBRA participant without receiving payment by the participant, the employer can deactivate the member and would receive a credit for any months paid on behalf of the participant, on their next invoice.
- If no payment has been made, the deactivation would be processed with no credit.

How does the plan recover claim dollars if claims are paid and premiums are not collected?
Update 8/12

If a COBRA member has not paid premium, claims would not be paid until premiums are paid.

COBRA SUBSIDY - RESCUE ACT

On March 11, 2021, the **American Rescue Plan Act of 2021** (ARPA) was signed by President Biden and includes a provision for a COBRA continuation coverage premium subsidy of 100% for individuals and families who experienced involuntary job loss or a reduction in hours of work leading to a loss in coverage.

This subsidy will be available for assistance eligible individuals (AEIs), as defined under the Act, from April 1, 2021 through September 30, 2021.

COBRA participants must meet the below criteria in order to be an assistance eligible individual (AEI):

- Coverage was lost due to involuntary job loss or a reduction in hours of work.
- The COBRA participant is still within the COBRA eligibility period as of April 1, 2021 or elected COBRA and discontinued it prior to April 1, 2021.
- Eligible COBRA participants who do not have an election in place will have the opportunity to elect coverage during an Extended Election Period and will be able to take advantage of the subsidy effective April 1, 2021. This will be referred to as the "lookback period" in determining member eligibility.
- COBRA elected under the APRA will start April 1, 2021 and may go through September 30, 2021.
- The APRA will not extend the normal 18-month period of COBRA continuation coverage in the case of job loss or a reduction in hours.
- Eligible COBRA participants who have an election in place as of April 1, 2021 will be able to take advantage of the subsidy effective April 1, 2021.

- Eligible COBRA participants who become eligible for COBRA continuation coverage on or after April 1, 2021 will be eligible for the subsidy while it is in effect.

We continue to navigate the requirements and impact to COBRA eligible members and will provide updates as they are available.

Who can apply for assistance? New 3/17/2021

The subsidy applies to an "assistance eligible individual," which may include an employee and their dependents who had elected or will elect COBRA.

What amount is covered and who pays for the premium? New 3/17/2021

The 100% subsidy covers the COBRA premium including the 2% administrative fee that health plans are permitted to charge for COBRA.

For COBRA, the premium is advanced by the employer for fully insured or self-funded groups of 20 or more employees. The eligible individual does not pay the COBRA premium. For state continuation of coverage laws for groups 1 to 19, the insurer handles the premium. This is sometimes called mini COBRA.

In both cases, either the employer for large group or the insurer for small groups 1 to 19 would then be reimbursed by the government for the premium through a refundable tax credit against the Medicare hospital insurance tax.

How does the tax credit work for insured or self-funded plans or multiemployer plans? Update 3/26/2021

The American Rescue Plan specifically states that the *employer* is the entity that claims the tax credit for both insured and self-funded coverage where the employer's group health plan is subject to COBRA under the Code, ERISA, or the PHSA. This is like the ARRA COBRA subsidy provisions were implemented from 2009.

- For an insured or self-funded plan, the employer advances the premium and gets the tax credit.
- For a multiemployer plan, the plan advances the premium and gets the tax credit.
- For state continuation of coverage, the insurer would cover the premium and gets the tax credit.

In other words, what Congress states is that if the plan is fully insured and subject to federal COBRA (via ERISA, the Code, or the PHSA), then the employer pays the premium and gets the tax credit. But, if the plan is fully insured not subject to federal COBRA, but subject to another COBRA provision such as state continuation or mini COBRA, then the insurer gets the tax credit. For self-funded plans the employer pays the premium and gets the credit.

For what time period are the subsidies covered at 100%? New 3/17/2021

The subsidy will begin for coverage periods beginning on April 1, 2021 and ending on September 30, 2021. The subsidy would end sooner if the qualified beneficiary's maximum COBRA coverage period ends or if the individual is eligible for another group health plan or Medicare.

How would subsidies work if the individual was terminated or their hours resulted in loss of health benefits prior to April 1, 2021? New 3/17/2021

The Act also provides additional enrollment options for individuals who already had an involuntary termination of employment or reduction in hours within the last 18 months and did not timely elect COBRA or dropped COBRA. These individuals have a new 60-day election period following the date that they receive a new required COBRA notice.

Additionally, employers are permitted but not required to allow assistance-eligible individuals to change elections to other plan options that have the same or lower cost premiums.

Are new notices or other communications required to be sent to eligible individuals? New 3/17/2021

Employers are required to update COBRA notices sent to assistance eligible individuals to describe the subsidy and to issue extended COBRA election notices within 60 days of the date of applicability.

Failure to update and send a new COBRA notice to an eligible individual would be treated as a failure of the COBRA notice requirements. Employers also must provide a notice of expiration before the premium subsidy expires.

The legislation describes content for these notices and the Secretary of Labor has been directed to publish Model Notices.

TESTING

Overview — Update 10/17/2021

Testing is important to slowing the spread of COVID-19. We encourage our members and health care providers to use **FDA-authorized tests**. There are two types of COVID-19 tests:

- **Diagnostic tests** determine if you are currently infected with COVID-19.
- **Antibody tests** may determine if you might have been infected with the virus. According to the FDA, antibody tests should not be used to diagnose a current infection.

For UnitedHealthcare members there is $0 cost-share (copayment, coinsurance or deductible) on medically appropriate COVID-19 testing during the national public health emergency period, currently scheduled to end January 15, 2022.

- Medically appropriate testing is ordered by a physician or health care professional for the purposes of diagnosis or treatment.
- Tests must be FDA-authorized to be covered without cost-sharing.
- This coverage applies to in-network and out-of-of-network tests for Medicare Advantage, Exchange, Individual and Employer-sponsored health plans through the national public health emergency period. For individuals enrolled in UnitedHealthcare Community Plans, state variations and regulations may apply during this time.

UnitedHealthcare benefit plans generally do not cover testing for employment, education, travel, public health or surveillance purposes, unless required by law.

Members who think they need a COVID-19 test, should talk to their health care provider.

What is meant by diagnostic and antibody tests for COVID-19? Update 12/29

Diagnostic tests for COVID-19 include virus and antigen detection test that determine if a person is currently infected with COVID-19. An antibody (serology) COVID-19 test may determine if a person has been exposed to COVID-19.

During the national public health emergency period, Individual and Employer Sponsored health plans, Exchange plans and Medicare Advantage plans will cover medically appropriate COVID-19 testing at no cost-share (copayment, coinsurance or deductible) when ordered by a physician or health care professional for purposes of diagnosis or treatment of an individual member.

Does UnitedHealthcare Global Solutions cover pre-travel testing or surveillance testing? Update 6/22/2021

UnitedHealthcare Global Solutions is covering medically appropriate COVID-19 diagnostic testing (virus/antigen) at no cost-share when ordered by a physician or appropriately licensed health care professional for purposes of diagnosis or treatment of an individual member.

UnitedHealthcare Global Solutions health benefit plans generally do not cover testing for surveillance, including travel or pre-travel screening, or public health purposes unless required by applicable law.

Can pharmacists order and administer COVID-19 diagnostic and antibody tests? New 7/7

Yes. HHS authorized licensed pharmacists to order and administer COVID-19 tests that the FDA has approved through the emergency authorization. The guidance was issued on April 8, 2020 under the PREP Act. Pharmacists, in partnership with other health care providers, are well positioned to aid COVID-19 testing expansion. Pharmacists are health care professionals with established relationships with their patients. The vast majority of Americans live close to a retail or independent community-based pharmacy. Pharmacists also have strong relationships with medical providers and hospitals to appropriately refer patients when necessary.

DIAGNOSIC TESTING

Does UnitedHealthcare cover the diagnostic test for COVID-19? Update 10/17/21

UnitedHealthcare and its self-funded customers will waive cost sharing (copayment, coinsurance, and deductible) for medically appropriate COVID-19 diagnostic testing during this national emergency. We are also waiving cost sharing for COVID-19 diagnostic testing related visits during this same time, whether the testing related visit is received in a health care provider's office or through a telehealth visit. This coverage applies to Medicare Advantage, Medicaid and fully insured and self-funded employer-sponsored plans.

Testing must be ordered by a physician or appropriately licensed health care professional and provided at approved locations in accordance with U.S. Centers for Disease Control and Prevention (CDC) guidelines including FDA approved testing at designated labs around the country.

Cost share will be waived for testing and testing-related services during the national public health emergency beginning on February 4, 2020. The Secretary of HHS renewed the National Public Health Emergency through January 15, 2022.

What constitutes an FDA-approved test mean? New 6/16

Tests must be FDA authorized to be covered without cost sharing (copayment, coinsurance or deductible). FDA-authorized tests include tests approved for patient use through pre-market approval or emergency use pathways, and tests that are developed and administered in accordance with FDA specifications or through state regulatory approval.

Is the COVID-19 diagnostic test and test-related visits covered for self-funded clients? Update 4/22

Self-funded customers including HDHP/HSA must waive member cost sharing, including copayments, coinsurance and deductibles, for COVID-19 diagnostic test and test-related visits including related items and services at physician office, urgent care, emergency room, or through a telehealth visit that are covered under the member's plan.

Who qualifies as "appropriately licensed" to order a covered diagnostic or antibody test? New 6/8

Licensure requirements vary by state. In some states, a pharmacist or other health care professional, such as a nurse practitioner, would have the appropriate licensure to order a test. Please refer to state-specific licensure requirements for appropriate guidance on who would qualify in your state.

Can an administrative services-only (ASO) customer choose to only cover in-network testing? New 6/8

During the national public health emergency period, cost share is required to be waived for testing, both in and out of network.

Will UnitedHealthcare cover public surveillance screening? New 6/8

Testing conducted through a federal, state or local entity for public surveillance will be paid for by that coordinating entity.

Does UnitedHealthcare cover back to work or back to school testing? Update 6/21/21

UnitedHealthcare will cover testing for employment, education, public health, or surveillance purposes when required by applicable law, otherwise covered for testing is not covered. Benefits will be adjudicated in accordance with a member's benefit plan. Health benefit plans generally do not cover testing for surveillance or public health purposes.

We continue to monitor regulatory developments during emergency periods.

Would mileage expenses be reimbursable for concierge services or other items related to obtaining COVID-19 testing? New 4/22

No, Items or services not covered under a member's plan would not be covered for COVID-19 testing or testing related services. For example, mileage expense, transportation, meals, etc. are not covered.

Do high-deductible plans with a Health Savings Account (HSA) cover the COVID-19 diagnostic test prior to reaching a deductible? Update 4/10

Yes. Such plans must cover the COVID-19 diagnostic test and test-related visit at no cost share prior to the member meeting their deductible. If the member has already reached their deductible there is no additional deductible.

Will diagnostic testing for COVID-19 be covered as a preventive service under the Affordable Care Act (ACA)?

The cost of COVID-19 diagnostic testing is considered an essential health benefit but is not classified as an ACA preventative health benefit.

Does the provider or lab need to use a specific HCPCS code to have the COVID-19 diagnostic test covered? Update 5/31

For a complete list of testing and related COVID-19 codes, go to uhcprovider.com.

Yes. The new HCPCS and CPT codes to cover the diagnostic test are:

- U0001- to be used for the tests developed by the Centers for Disease Control and Prevention (CDC).
- U0002 – Used by laboratories performing non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).
- CPT Code 87635 –Pathology and Laboratory code for severe acute respiratory syndrome coronavirus 2 (SARS-2-Co-2). Most national laboratories will use this code.
- CPT Code 99001 –If specimen is collected somewhere other than physician's office.

Codes apply to fully insured and self-funded plans in- and out-of-network.

There will be diagnosis codes specific to the virus that will be billed for testing related visits. They are as follows:

- Z03.818 - Used for cases where there is a concern about a possible exposure to COVID -19.
- Z20.828 - Used for cases where there is an actual exposure to someone who is confirmed to have COVID-19.
- Z11.59 - For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative.

For specific codes related to COVID-19 related to testing, treatment, coding and reimbursement visit uhcprovider.com.

Are there tools to help people understand their symptoms or find a testing site near them? New 4/6

Yes, UnitedHealthcare is committed to helping people protect their health by expanding access to care, support and resources during this unprecedented time. By going to the myuhc.com pre login website people may use the online symptom checker to assess their risk for COVID-19 and get treatment options.

The Test Locator tool helps individuals find a COVID-19 diagnostic test location in their area. In most test locations they will ask for a script from a provider. Use the telehealth option to contact a provider for a script.

For members, by signing in to myuhc.com there are additional resources and care information access to member benefits.

Where can a member go to get a COVID-19 diagnostic test?

If someone thinks they have been exposed to COVID-19 and develops symptoms such as fever, cough and/or difficulty breathing, they should first **CALL** a health care professional for medical advice. The provider will use their judgment to determine if a patient should be tested. The provider may collect a respiratory specimen or in certain situations the provider may refer a member to one of the approved testing locations and UnitedHealthcare will cover the COVID-19 diagnostic test and test-related visit with no cost sharing (copayment, coinsurance, and deductible).

Does UnitedHealthcare cover antigen tests? Update 7/24

Yes, antigen tests are diagnostic tests and covered through the national public health emergency, when approved by the FDA or FDA emergency approval and are ordered by a provider.

Will UnitedHealthcare cover the "rapid" point of care testing for COVID-19? New 3/30

UnitedHealthcare will cover COVID-19 diagnostic testing for members enrolled in Commercial, Medicare Advantage, and Medicaid plans. Coverage includes the recently announced "rapid" point of care" COVID-19 diagnostic test that has been authorized under the FDA Emergency Use Act (EUA). This testing will be available to patients tested in clinical settings who are equipped to run the test, such as urgent care and emergency departments. The "rapid" point of care diagnostic test will be billed under the same CPT code (87635) as the other COVID-19 diagnostic tests.

This test has been authorized only for the COVID-19 diagnostic test and not for any other viruses or pathogens.

Are diagnostic tests readily available from physicians? Update 4/19

The COVIID-19 diagnostic tests are being made available now but check with your physician to see if they have the test or where you can you can go in your area for a test. A member may also check test site locations using the Test Locator Tool on myuhc.com.

If the physician requests a second test for COVID-19 to determine if the member is positive, would the second test be covered? New 4/20

Our claim payment is dependent upon accurate coding. If coded as a test, we will pay multiple COVID-19 tests at zero cost share.

What is the process if client requests to opt out of covering the diagnostic test or test related expenses?

Based on federal legislation passed on March 18, 2020, all plans are required to cover these services without cost sharing (copayment, coinsurance, and deductible) during the emergency period.

Will drive-up diagnostic testing be an option?

Yes. If your health care provider determines you should be tested for COVID-19 and orders the diagnostic test, they should work with local and state health departments to coordinate testing. As long as the testing place is at an FDA approved facility/location and administered in accordance CDC Guidelines, it will be covered.

Will UnitedHealthcare cover COVID-19 testing at Walgreens' drive up test sites? Update 8/14

The Walgreens' drive up test sites includes the physician network (PWNHealth) that will be screening and ordering the test as deemed appropriate. The test is FDA-authorized. When a claim is submitted with the proper physician coding, UnitedHealthcare will reimburse at no cost share.

During the national public health emergency period, UnitedHealthcare will cover medically appropriate COVID-19 testing at no cost share when ordered by a physician or appropriately licensed health care professional for purposes of diagnosis or treatment of an individual member.

Does UnitedHealthcare cover COVID-19 Home Tests? Update 12/8

The testing must be ordered by a physician or licensed health care professional and processed at approved locations in accordance with U.S. Centers for Disease Control and Prevention (CDC) guidelines including FDA approved testing at designated labs around the country.

Cost share will be waived for testing and testing-related services during the national public health emergency. Claims must be coded appropriately for COVID-19 diagnostic testing including home tests.

At this time home tests including saliva tests that have FDA approval or emergency use authorization (EUA) are covered for diagnosis.

Call your health care provider right away if you believe you might have been exposed to COVID-19 or have symptoms such as fever, cough or difficulty breathing. If your health care provider determines you should be tested for COVID-19 and orders a test, they should continue to work with local and state health departments to coordinate testing, or use COVID-19 diagnostic testing authorized by the Food and Drug Administration under an Emergency use Authorization through clinical laboratories.

Does UnitedHealthcare cover saliva tests? Update 12/8

Saliva test that have either FDA approval or emergency use authorization are covered for diagnosis.

The testing must be ordered by a physician or licensed health care professional and processed at approved locations in accordance with U.S. Centers for Disease Control and Prevention (CDC) guidelines including FDA approved testing at designated labs around the country.

Cost share will be waived for testing and testing-related services during the national public health emergency. Claims must be coded appropriately for COVID-19 diagnostic testing including home tests.

Can a member self-refer for the test?

No. A member should call their physician right away if they believe they have been exposed to COVID-19. The provider will have special procedures to follow. If the provider feels a COVID-19 diagnostic test is indicated, the provider will collect a respiratory specimen. In certain situations, the provider may refer a member to an approved testing location and UnitedHealthcare will cover the test at without cost sharing.

If the test comes back positive for COVID-19 will my treatment be covered? Update 10/5

UnitedHealthcare is waiving member cost share for the applicable network treatment of COVID-19 through December 31, 2020 and for applicable out of network treatment of COVID-19 through October 22, 2020, for fully insured commercial plans. We work with self-funded customers who want to implement a similar approach on their behalf.

Are more labs, such as LabCorp and Quest, available for testing?

Yes, per the CDC as of March 23, the total number of public health laboratories (PHL) that have completed verification and are offering testing is 91. This includes one or more PHL in 50 states plus DC, Guam and Puerto Rico. CDC is updating this information regularly.

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/testing-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Ftesting-in-us.html

Should children exhibiting symptoms be tested?

UnitedHealthcare encourages members with children to contact their child's pediatrician, who will review the symptoms and determine if a test is recommended.

How long before test results are known?

Test results were taking three to four days early on; however, that is speeding up with the incorporation of more labs. A 24-48-hour turnaround now is more common.

Can telehealth providers evaluate symptoms and send the individual for a COVID-19 diagnostic test?

A telehealth provider may determine whether the individual should be sent to a CDC approved location for a COVID-19 diagnostic test. The COVID-19 diagnostic test and test-related telehealth visit is paid at no cost share.

Will zero cost share be available for an employee that is required to remain outside of the country due to COVID-19? New 4/4

Coverage for the test and test related visits will be paid at zero cost share. The claim is processed by transaction accommodating the foreign exchange rate according to the terms in the member's plan.

ANTIBODY TESTING

Will UnitedHealthcare waive cost share for COVID-19 antibody testing? Update 10/17/21

During the national public health emergency period, UnitedHealthcare will cover medically appropriate FDA-authorized COVID-19 antibody tests ordered by a physician or appropriately licensed health care professional without cost sharing (copayment, co-insurance or deductible). This coverage applies to members enrolled in Medicare Advantage, Medicaid, and Individual and Group Market health plans. Benefits will be otherwise adjudicated in accordance with the member's health plan.

An antibody test may determine if a person has been exposed to COVID-19, while a COVID-19 diagnostic test determines if a person is currently infected. FDA-authorized tests include FDA-approved tests, and tests used in an office or lab that are developed and administered in accordance with FDA specifications or through state regulatory approval. According to the FDA, an antibody test should not be used as the sole basis for diagnosis. UnitedHealthcare strongly supports the need for reliable testing and encourages health care providers to use reliable FDA-approved tests.

UnitedHealthcare is requesting all physicians and health care professionals who perform and bill for COVID-19 antibody tests to register the tests you will use for our members. UnitedHealthcare will use the registration information to assist health care professionals in choosing tests that are FDA-approved and to better understand the clinical reliability of the tests being used. Additional instructions on test registration are provided on UHCprovider.com/covid19.

UnitedHealthcare will use the registration information to assist providers in choosing tests that are FDA-approved and to better understand the clinical reliability of the tests being used.

Coverage is effective for dates of service April 10, 2020 which aligns with the date coding was made available, through the public health emergency, currently January 15, 2022.

Who qualifies as "appropriately licensed" to order a covered diagnostic or antibody test? New 6/8

Licensure requirements vary by state. In some states, a pharmacist or other health care professional, such as a nurse practitioner, would have the appropriate licensure to order a test. Please refer to state-specific licensure requirements for appropriate guidance on who would qualify in your state.

What is UnitedHealthcare's position on antibody (serology) testing? New 6/8

Per FDA guidelines, antibody tests should not be used to diagnose a current infection. An antibody test detects antibodies in the blood when the body is responding to a specific infection and may determine if a person has been exposed to the virus SARS-CoV2 that causes COVID-19. A positive result for the antibody test has not been determined to confer immunity, as the strength and duration of the antibodies are still being researched.

The AMA "cautions physicians and the general public about use of these tests to determine individual immunity and warns that public health decisions, such as discontinuation of physical distancing, should not be made on the basis of results."

Can an administrative services-only (ASO) customer choose to only cover in-network testing? New 6/8

During the national public health emergency period, cost share is required to be waived for testing, both in and out of network.

Will UnitedHealthcare cover public surveillance screening? New 6/8

Testing conducted through a federal, state or local entity for public surveillance will be paid for by that coordinating entity.

Does UnitedHealthcare cover back to work or back to school testing? Update 6/21/21

UnitedHealthcare will cover testing for employment, education, public health or surveillance purposes when required by applicable law, otherwise coverage is denied. Health benefit plans generally do not cover testing for surveillance or public health purposes. We continue to monitor regulatory developments during emergency periods.

Has CMS published rates for antibody tests? Update 5/31

Yes. The published rates for antibody tests are:

- CPT Code 86789 — $ 42.13

  Antibody; severe acute respiratory syndrome coronavirus2 (SARS-CoV-2)

- CPT Code 86328 — $ 45.23

  Immunoassay for infectious agent antibody or antibodies, qualitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus2 (SARS-CoV-2)

Codes for COVID-19 services are on uhc.provider.com.

Does UHC cover antibody detection tests (Serology - IGG/IGM/IGA for SARS-nCOV2 (COVID19)? Update 10/17/21

During the national public health emergency period, UnitedHealthcare will cover FDA-authorized COVID-19 antibody tests ordered by a physician or appropriately licensed health care professional without cost sharing (copayment, co-insurance or deductible). This coverage applies to members enrolled in Medicare Advantage, Medicaid, and Individual and Group Market health plans. Benefits will be otherwise adjudicated in accordance with the member's health plan.

An antibody test may determine if a person has been exposed to COVID-19, while a COVID-19 diagnostic test determines if a person is currently infected. FDA-authorized tests include FDA-approved tests, and tests used in an office or lab that are developed and administered in accordance with FDA specifications or through state regulatory approval. According to the FDA, an antibody test should not be used as the sole basis for diagnosis. UnitedHealthcare strongly supports the need for reliable testing and encourages health care providers to use reliable FDA-approved tests.

UnitedHealthcare is requesting all physicians and health care professionals who perform and bill for COVID-19 antibody tests to register the tests you will use for our members. UnitedHealthcare will use the registration information to assist health care professionals in choosing tests that are FDA-

approved and to better understand the clinical reliability of the tests being used. Additional instructions on test registration will be provided on UHCprovider.com/covid19 on May 8, 2020.

In the coming weeks, UnitedHealthcare will use the registration information to assist providers in choosing tests that are FDA-approved and to better understand the clinical reliability of the tests being used.

The national public health emergency as renewed will end after January 15, 2022. COVID-19 testing is rapidly evolving and UnitedHealthcare will continue to provide updates as they become available. Be sure to check back often for the latest information.

During the national emergency period is a self-funded customer required to cover an antibody test? New 6/6

Yes. Self-funded clients are automatically opted in to covering the antibody tests with medical professional order at no cost share during the national emergency period.

VIRTUAL VISITS AND TELEHEALTH

Note: The Public Health Emergency was extended by HHS through January 15, 2022.

What is the role of Telehealth/Virtual Visits? Update 9/28

With the help of communication technologies, many members can now interface with health care providers from the comfort of their own home. This may be especially helpful during a pandemic. It can help individuals know if they should get a COVID-19 diagnostic test while practicing social distancing.

UnitedHealthcare offers two models of digital access to providers:

Virtual Visits, which are included in many commercial plans, allow members to contact one of three national providers that provide access to physicians, and offer a range of services for acute non-emergent needs. To start a Virtual Visit, the member may login to myuhc.com. Where necessary, the Virtual Visit provider may refer the patient to be seen by their own provider or specialist.

Telehealth services provide the member with the ability to contact their own choice of physician in the rather than going through a Virtual Visit provider. The visit may be audio (telephone) or audio-visual communication with the patient.

If persons are experiencing symptoms or think they might have been exposed to COVID-19, they should contact their health care provider and ask what telehealth options may be available.

Members should consult their plan and/or their provider for information about and access to either Virtual Visit or Telehealth options.

When available through the members benefit plan, either telehealth services or the Virtual Visit benefit may be a preferred option to an in-person visit, allowing faster support and reducing exposure to the virus or exposing others to the virus. Telehealth and Virtual Visits both help reduce demand on the health care system as it addresses the needs created by the virus.

What is changing for telehealth services? Update 10/17/21

Individual and fully insured Group Market health plans:

- **COVID-19 and non-COVID-19 in-network telehealth visits:** The expansion of telehealth access is extended through Dec. 31, 2020. This means members may access care through health care professionals who can temporarily provide telehealth services by a live interactive audio-video or audio-only communications system for members at home or another location.
- **For COVID-19** in and out-of-network COVID-19 diagnostic test-related telehealth visit, cost share is waived through the national public health emergency, currently January 15, 2022.
- **For COVID-19** in network telehealth treatment, cost share is waived through Dec. 31, 2020. As of Jan. 1, 2021, coverage for in- and out-of-network telehealth services related to COVID-19 treatment will be determined by your benefit plan. You will be responsible for any copay, coinsurance or deductible.
- **COVID-19 out-of-network telehealth visits:** The expansion of OON telehealth access ends Oct. 22, 2020. As of Oct. 23, 2020, out-of-network telehealth services are covered according to the member's benefit plan and UnitedHealthcare's telehealth reimbursement policy.

- **Non-COVID-19 out-of-network telehealth visits:** The expansion of telehealth access ended July 24, 2020. As of July 25, 2020, out-of-network telehealth services are covered according to the member's benefit plan and UnitedHealthcare's telehealth reimbursement policy.
- **January 1, 2021 coverage for telehealth visits not related to COVID-19:** Members may have telehealth visits from their home with their network providers. Coverage for in- and out-of-network telehealth visits not related to COVID-19 will be determined by your benefit plan. You will be responsible for any copay, coinsurance or deductible.

Some states have established state-specific rules, regulations and emergency periods that apply to Individual and fully insured Group Market health plans. These may vary from federal regulations.

COVID-19 Related

Expanded Telehealth. For medical and outpatient behavioral telehealth visits, eligible providers can utilize both interactive audio/video and audio-only. For PT/OT/ST provider visits, interactive audio/video technology must be used. Visit limits may apply.

What are UnitedHealthcare Telehealth and Virtual Visit guidelines? Update 12/29

To increase system access and flexibility when it is needed most, we are expanding our telehealth policies to make it easier for people to connect with their health care provider. People will have access to expanded telehealth services in two ways – through a Virtual Visit national provider or through a medical provider, such as the members physician.

- **Expanded Provider telehealth Access for COVID-19** — Effective March 18, and through December 31, 2020, all eligible network medical providers who have the ability and want to connect with their patient through synchronous virtual care (live video conferencing) or audio-only (telephone) can do so. Effective dates may vary based on state laws. This applies to all fully insured clients and self- insured clients that are following the fully insured guidelines.

COVID-19 Coverage

- **COVID-19 Telehealth:** Through the public health emergency, cost share is waived (copayment, deductible, coinsurance) for in-network and out-of-network telehealth coverage for COVID-19-related test-related visit and services.
- **COVID-19 Telehealth in-network treatment:** From Feb. 4, 2020, through Dec. 31, 2020, UnitedHealthcare is waiving cost sharing for in-network telehealth treatment visits.
- **Non COVID in-network telehealth services:** Through September 30, 2020, cost share is waived for in-network non-COVID covered telehealth services, for individual and fully insured group market health plans, and for self-funded employers that opted in.
- **Non COVID out-of-network telehealth services:** Out-of-network telehealth services do not include the cost-share waiver and is processed in accordance with the group's health benefits plan if the service is eligible. Expanded telehealth non-COVID-19 services ended July 24, 2020.
- **January 1, 2021 coverage for telehealth visits not related to COVID-19:** Members may have telehealth visits from their home with their network providers. Coverage for in- and out-of-network telehealth visits not related to COVID-19 will be determined by your benefit plan. You will be responsible for any copay, coinsurance or deductible.

Virtual Visit Coverage

- **COVID-19 Virtual Visits**: For individual and group market health plan members in plans that include Virtual Visits, many members can access their Virtual Visits benefits through one of UnitedHealthcare's national designated providers without any cost share (copayment, deductible or coinsurance) through the public health emergency — Doctor on Demand, AmWell, Teladoc. Beginning October 1, the member will pay the copay upfront and will be reimbursed for the copay for COVID-19 diagnosis claims once the claim has been reprocessed.
- **Non-COVID Virtual Visits:** For individual and group market health plan members, many members can access their Virtual Visits non-COVID-19 benefits through one of UnitedHealthcare's national designated providers without any cost share (copayment, deductible or coinsurance) through September 30, 2020 — Doctor on Demand, AmWell, Teladoc.

Is there a Virtual Visit option for members? Update 10/13

Virtual Visit options are available to members in many plans. Where available, and if covered under their plan, members can schedule a Virtual Visit with a provider. Virtual Visit providers Teladoc®, Doctor On Demand™ and AmWell® have developed guidelines for members who think they may have been infected by COVID-19.

A member's Virtual Visit is a good place to discuss concerns and symptoms. Where indicated, the Virtual Visit provider may refer the member to their physician.

HealthiestYou provides Virtual Visit support for All Savers plan members.

Through October 22, 2020, HealthiestYou provides Virtual Visit support small group (PRIME) fully insured grandfathered plans on a COC earlier than 2016 and transitional relief (TR) plans. After October 22, 2020, members in grandfathered or transitional relief plans may continue to have telehealth visit coverage with their own physician. The HealthiestYou pilot markets for grandfathered plans and TR plans will still be able to use HealthiestYou as they did prior to the pandemic.

What is the member coverage and cost share for telehealth? Update 10/17/21

For COVID-19 in- and out-of-network test related telehealth visits, UnitedHealthcare will waive cost sharing from Feb. 4, 2020 through the national public health emergency, currently January 15, 2022. This applies to telehealth test related visits for all fully insured clients and self- insured clients that are following the fully insured guidelines.

- From Feb. 4, 2020, through Dec. 31, 2020, UnitedHealthcare is waiving cost sharing for in-network telehealth treatment visits.
- For non-COVID-19 in-network only telehealth services, UnitedHealthcare will waive cost sharing from March 31, 2020 through Sept. 30, 2020. This applies to all fully insured clients and self-insured clients that are following the fully insured guidelines.
- Expanded telehealth applies to related visits for medical, outpatient behavioral and PT/OT/ST, chiropractic therapy, home health, and remote patient monitoring services, with opt-in available for self-funded employers.
- For COVID-19 testing-related telehealth visits cost sharing will be waived through the national public health emergency period for all members.

- **January 1, 2021 coverage for telehealth visits not related to COVID-19:** Members may have telehealth visits from their home with their network providers. Coverage for in- and out-of-network telehealth visits not related to COVID-19 will be determined by your benefit plan. You will be responsible for any copay, coinsurance or deductible.

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Will UnitedHealthcare waive cost share for Virtual Visits through Teladoc®, Doctor On Demand™ and AmWell®? Update 10/17/21

UnitedHealthcare will waive cost-share (copayment, deductible, and coinsurance) for all COVID- 19 Virtual Visits through the public health emergency, currently January 15, 2022. Non-COVID-19 coverage at no cost share ends September 30, 2020.

Beginning October 1, 2020 members will pay the copay for both COVID-19 and non-COVID-19 services. The copay COVID-19 services with a COVID diagnosis will be reimbursed to the member.

This change will only apply to customers who have Virtual Visits through UnitedHealthcare.

How does the telehealth change apply to UnitedHealthcare's Virtual Visit program? Update 10/13

For fully insured customers and self-funded customers following UnitedHealthcare fully insured standard benefits, we waive cost share for all Virtual Visits, not limited to COVID-19, until September 30, 2020.

This change applies to customers who offer Virtual Visits through UnitedHealthcare Virtual Visit providers–- Teladoc, Doctor on Demand, and AmWell. For All Savers, grandfathered plans and transitional relief plans, HealthiestYou is the Virtual Visit approve provider. After October 22, Grandfathered plans and transitional relief plans will no longer have Virtual Visits but will continue to have telehealth through December 31, 2020, when the new UnitedHealthcare telehealth program will begin.

- COVID-19 claims will be processed at zero cost share (copayment, deductible, and coinsurance) for COVID related virtual visits for dates of service February 4, 2020, forward. For individual and group market health plan members in plans that include Virtual Visits, many members can access their Virtual Visits benefits through the public health emergency. Beginning October 1, the member will pay the copay upfront and will be reimbursed for the copay for COVID-19 diagnosis claims once the claim has been reprocessed.
- Non COVID-19 Virtual Visits for fully insured plans with Virtual Visits or for ASO plans that followed UnitedHealthcare fully insured began March 18, 2020. Non-COVID Virtual Visit coverage at no cost share ends September 30.

Virtual Visits are available to group plans with the Virtual Visit benefit. A plan change is required to add **new** Virtual Visits coverage through UnitedHealthcare's arrangement with AmWell, Doctor on Demand, and Teledoc and HealthiestYou (All Savers). Adding Virtual Visit coverage cannot be done retroactively.

For All Savers level-funded members already have access to Virtual Visits through our partnership with HealthiestYou at no cost share. However, for the All Savers fully insured membership that does not currently have access to this benefit, this service will be available to them through the public health emergency at no cost to the group or member.

Can a Virtual Visit provider order the COVID-19 diagnostic test? New 4/2

At this time, the Virtual Visit provider follows the CDC guidance. When a Virtual Visit doctor identifies a COVID suspected case, they advise individuals to call their local doctor or their state's public health hotline to verify test availability and to "let them know before you go" so that the in-person care facility can direct them appropriately and minimize potential exposure for others.

Additionally, they contact the appropriate public health department in accordance with local reporting requirements. Each public health department defines its own parameters regarding what notifications are required and how they contact patients to initiate diagnostic testing, conduct contact tracing and/or implement at-home self-monitoring, at-home supervised isolation, or quarantine requirements.

Can a member use both audio-visual and audio only for a Telehealth visit? Update 9/28

Through the national public health emergency, UnitedHealthcare will waive the Centers for Medicare and Medicaid's (CMS) originating site restriction and audio-video requirement for UnitedHealthcare group members. UnitedHealthcare members may have a telehealth visit with a health care provider using either audio-video or audio-only while a patient is at home.

How will UnitedHealthcare reimburse providers for a Telehealth encounter? Update 11/3

For fully insured plans and self-funded plans that provide standard fully insured benefits, UnitedHealthcare will reimburse providers who submit appropriate telehealth test related claims for COVID-19 diagnoses according to its telehealth reimbursement policies and terms of applicable member benefit plans through the national public health emergency. UnitedHealthcare is waiving cost sharing for in-network telehealth treatment visits through Dec. 31, 2020.

Telehealth services for non-COVID-19 diagnosis will be reimbursed at no cost share through September 30, 2020.

COVID-19 test-related visit and applicable treatment will be reimbursed at no cost share (copayment, deductible or coinsurance) for self-funded customers that cover COVID-19 telehealth services through the national emergency.

Members experiencing symptoms or think they might have been exposed to COVID-19 should call their health care provider right away and ask what telehealth options may be available.

Which types of care providers do the policy changes apply to? New 3/29

UnitedHealthcare generally follows CMS' policies on the types of care providers eligible to deliver telehealth services, although individual states may define eligible care providers differently. These include:

- Physician
- Nurse practitioner

- Physician assistant
- Nurse-midwife
- Clinical nurse specialist
- Registered dietitian or nutrition professional
- Clinical psychologist
- Clinical social worker
- Certified registered nurse anesthetists

Can a member receive care from a psychiatrist, psychologist, therapist, ABA, or other behavioral health specialists from their home? New 4/7

Yes. Immediate telehealth care options are available to all Behavioral Health providers during the national COVID-19 health crisis – these can be done telephonically or via video technology.

Telephonic Care

For providers who do not have access to HIPAA-approved technology typically required to conduct a video-enabled virtual session, or video chat platforms as listed below, telephonic services can begin immediately.

Video-enabled Technology Care

HIPAA-approved technology can continue to be used by providers to deliver telehealth care to members. For providers who do not have access to HIPAA-approved technology to conduct a virtual video-enabled session, providers may conduct these sessions immediately using any nonpublic-facing remote communications product that is available to communicate with members as listed below in accordance with OCR's Notice. Providers are responsible to provide telehealth services in accordance with OCR's Notice and may use:

- HIPAA-approved telehealth technologies
  - Popular applications that allow for video chats may be used during the current nationwide public health emergency — including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype — to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
  - Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.
- Platforms NOT approved: Facebook Live, Twitch, Snapchat, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth to Behavioral Health plan members by covered health care providers.

What is UnitedHealthcare's member cost share policy for telehealth visits with a therapist, psychiatrist and ABA therapist during the crisis? Update 6/8

Fully Insured

- UnitedHealthcare is waiving the member cost-share for in-network behavioral telehealth visits. The behavioral telehealth video and telephonic support is available through qualified network

behavioral providers for all diagnoses at no cost share through September 30, 2020. This also applies to health care providers who are qualified and licensed in accordance with applicable regulations to provide ABA services.

Self-Funded

- Upon request UnitedHealthcare will support our self-funded customers who request waiving member cost share for behavioral telehealth services during the COVID-19 crisis.

Can members use Sanvello at no cost share? Update 9/28

Sanvello offered free premium access to its digital care delivery platform through June 30, 2020. For more information on Sanvello services, contact your UnitedHealthcare representative. Sanvello's provides clinically validated techniques, coping tools and peer support.

Can telehealth services be used for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)? Update 7/27

From March 18 through September 30, 2020, UnitedHealthcare will allow members of fully insured plans to use telehealth interactive audio-video technology with their physical, occupational and speech therapists while a patient is at home. Cost sharing (copayment, deductible, and coinsurance) is waived for network PT/OT/ST services with an in-network provider.

Through July 24, 2020, out-of-network visits would be paid based on the members benefit plan.

Upon request UnitedHealthcare will support our self-funded customers who request waiving member cost share for behavioral telehealth services during the COVID-19 crisis.

Can you clarify whether Telehealth can be offered and paid before the deductible has been met on a HDHP plan and not disqualify them from making HSA contributions? Update 9/7/21

Reminder: The if pre-deductible coverage for telehealth was included in HDHPs with HSAs through 2021, the pre-deductible coverage for telehealth, virtual visits must be removed for 2022 HDHPs with HSAs plans.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act had allowed HSA qualified high deductible health plans to cover telehealth services for any condition before the deductible is met. This change is effective for plan years on or before 12/31/2021.

Separately, in Notice 2020-15, posted to IRS.gov, the IRS notes that health plans that otherwise qualify as HDHPs will not lose that status merely because they cover the cost of testing for or treatment of COVID-19 before plan deductibles have been met, including but not limited to telehealth visits. The IRS also advised that, as in the past, any vaccination costs continue to count as preventive care and can be paid for by an HDHP. This notice applies only to HSA-eligible HDHPs.

In Notice 2020-15, posted to IRS.gov, the IRS notes that health plans that otherwise qualify as HDHPs will not lose that status merely because they cover the cost of testing for or treatment of COVID-19 before plan deductibles have been met. The IRS also advised that, as in the past, any vaccination costs continue to count as preventive care and can be paid for by an HDHP. This notice applies only to HSA-eligible HDHPs.

The COVID-19 diagnostic test, test-related physician office, urgent care, emergency room, Virtual Visit and telehealth visit and treatment will be covered at no cost share.

We will also cover these expenses under UnitedHealthcare stop loss policies for All Savers customers. We are advising customers to contact their UnitedHealthcare account representative to discuss options for coverage beyond our standard.

Employees and other taxpayers in any other type of health plan with specific questions about their benefits and what is covered should contact UnitedHealthcare by calling the number on the back of their ID Card.

Are telehealth visits covered for behavioral health as well as medical? Update 4/16

Due to recent and temporary rule changes made in response to COVID-19, more doctors and therapists are allowed to conduct phone or video sessions than the liveandworkwell.com directory may indicate. Make sure to ask all doctors and therapists if they can support telehealth visits when discussing your care. For FI clients, UnitedHealthcare has removed the cost-share (copayment, deductible, coinsurance) when provided by an in-network provider for mental health telehealth. ASO clients need to opt-in to allow mental health telehealth at no cost-share (copayment, deductive, coinsurance) when provided by an in-network provider. After September 30, the plan will pay according to plan benefits.

Since we are covering the medical diagnosis and treatment at 100% *if related to COVID-19*, is an employer required to also cover mental health services at 100% in order to be aligned with the Mental Health Parity and Addiction Equity Act? New 5/6 Response provided by Groom Law Group

While there has been no federal guidance regarding COVID-19 and the Mental Health Parity and Addiction Equity Act, we do not think that a group health plan is required to cover non-COVID-19 related services at 100% (including mental health) if the plan can show that the COVID-19 related coverage at 100% is only temporary, due to the COVID-19 public health emergency declared by the Secretary of Health and Human Services, and for the cost-share waiver for COVID-19 testing, due to a federal mandate.

Will employer groups with grandfathered plans and transitional relief plans be allowed to get virtual visits at no cost share? Update 10/13

Transitional Relief and fully insured Grandfathered groups on a COC earlier than 2016 will be eligible for virtual care at no cost through Healthiest You, a Teladoc Health company through October 22, 2020.

Will a customer lose grandfathered status if they adopt COVID plan changes? New 5/5

COVID plan changes to provide greater coverage related to the diagnosis and/or treatment of COVID-19 such as waiving cost share for COVID-19 testing and related office visit, treatment, and telehealth will not cause a plan to cease to be a grandfathered health plan, provided that no other changes are made that would cause a loss of grandfather status.

Are Virtual Visits covered for UnitedHealthcare Preventive Plan members? Update 3/27

Preventive Plan members do not have access to UnitedHealthcare's Virtual Visits program. However, if their personal physician offers telehealth services, they may utilize those services.

How does this Virtual Visit change apply to Oxford?

We implemented a Virtual Visit solution for our Oxford Fully Insured and self-funded members that not previously had this benefit available to them. The benefit is available via our member portal.

TREATMENT AND COVERAGE

What should I know about "long-haul" COVID-19? Update 10/15/21

According to the CDC, while most people get over COVID-19 within weeks of illness, some people experience post-COVID-19 conditions that continue 4 weeks or more after infection. Several recent studies show that between 27-33% of patients who get COVID-19 and were not hospitalized developed some lasting symptoms, no matter their age, prior health or severity of their infection.

While much is still unknown, the CDC reports these "long-haul" conditions can come to life in a variety of ways, ranging from difficulty breathing, fatigue, joint pain or mood changes to even more serious issues like multi-organ damage or autoimmune conditions. FDA-authorized and FDA-approved COVID-19 vaccines play an important role in preventing serious illness from COVID-19. Additional information on "long haul" COVID-19 is available on the CDC website.

How will UnitedHealthcare cover COVID-19 treatment? Update 2/26/2021

The health of our members and supporting those who deliver care are our top priorities, and UnitedHealthcare is taking additional steps to provide support during this challenging time. This builds on UnitedHealthcare's previously announced efforts to waive cost share for COVID-19 diagnostic testing and test-related visits and related items and services that are covered by the member's health plan.

If a member gets sick with COVID-19, their health care provider may prescribe treatments. A summary of coverage is below. If you have questions about your benefits, sign in to your health plan account or call the number on your member ID card.

- **Exchange, individual and fully insured Employer-sponsored plans:** For COVID-19 treatment, cost-sharing will be according to the member's benefit plan. Members will responsible for any copay, coinsurance or deductible. Coverage for out-of-network services will be determined by the individual's benefit plan. State variations may apply.
- **Medicare Advantage health plans:** You will have $0 cost-share for in-network and out-of-network COVID-19 treatment, including inpatient and outpatient treatment, through March 31, 2021.
- **For Members Enrolled in** UnitedHealthcare Community Plans**:** State provisions and regulations may apply during this time.

Does UnitedHealthcare cover treatment for COVID-19 members who are still sick months after a COVID-19 diagnosis? New 3/18/2021

UnitedHealthcare covers treatment for COVID-19 according to the member's health benefit plan. We do not limit ongoing health care coverage based on the time of a member's COVID-19 diagnosis.

Did UnitedHealthcare cover COVID-19 treatment at no cost share? New 2/1/2021

UnitedHealthcare waived member cost sharing for the applicable treatment of COVID-19 in network treatment through December 31, 2020, and out of network until October 22, 2020 for Individual and Group Market fully insured health plans. We worked with self-funded customers who wanted us to implement a similar approach on their behalf.

UnitedHealthcare had made the decision to extend medically necessary network inpatient COVID-19 treatment at no cost share for medical expenses for covered services. This extension applied for fully insured groups and for All Savers and ASO groups that follow UnitedHealthcare COVID-19 standard fully insured coverage between Jan. 1, 2021 and Jan. 31, 2021. This extension applied to inpatient COVID-19 treatment for members admitted with a COVID-19 diagnosis. We will also waive cost-share for COVID related FDA approved medications administered in these locations

If a member received network treatment under a COVID-19 admission or diagnosis code between Feb. 4, 2020 and December 31, 2020 or out of network COVID-19 treatment through October 22, 2020, we waived cost sharing (co-pays, coinsurance and deductibles) for the following: Office/telehealth visits, Urgent care visits, emergency department visits, observations stays, inpatient hospital episodes, acute inpatient rehab, long-term acute care, skilled nursing facilities. When available, we will also be waived cost-share for medications which are FDA-approved for COVID-19 treatment.

Does UnitedHealthcare cover outpatient monoclonal antibody treatment? Update 3/31/2021

The FDA has issued emergency use authorization for 2 monoclonal antibody treatments. According to the CDC, monoclonal antibody treatments may be recommended by a member's provider if they test positive for COVID-19, and are at risk to get very sick or to be admitted to the hospital. This treatment can help the body respond more effectively to the virus.

A summary of coverage for monoclonal antibody treatment is below. Sign in to your online UnitedHealthcare member account for more details.

- **Exchange, Individual and Fully Insured Employer-sponsored plans:** For monoclonal antibody treatments, you will have $ 0 cost-share with network providers in outpatient settings through Mar. 31, 2021. Beginning April 1, 2021, the monoclonal antibody treatment will pay according to plan benefits. Other COVID-19 outpatient treatments will be according to the member's benefit plan.
  Some self-insured health plans have different coverage benefits; if you have questions, please check with your human resources benefits team. Coverage for out-of-network services will be determined by your benefit plan.

- **Medicare Advantage plans: For monoclonal antibody treatments,** you will have $0 cost-share with in-network and out-of-network providers in outpatient settings through 2021. Medicare is paying for this treatment in 2021.

If a person was admitted to the hospital for COVID-19 treatment on January 31, 2021 or a patient is in the hospital but was not discharged by end of day January 31, 2021, what would be covered? Update 1/27/2021

For network patient care underway prior to January 31, 2021, the patient would be covered until the date of discharge if that is after January 31, 2021

Beginning February 1, 2021 coverage is at plan benefits.

States may mandate additional or differing requirements.

If an ASO client has agreed to waive member cost-share for the treatment of COVID-19 and a member with an underlying co-morbidity (i.e. such as diabetes, heart disease etc.) has an inpatient stay for treatment of the virus, will hospitals be able to split the inpatient bill so that member cost-share will not apply to the COVID-19 treatment but will apply to services related to the co-morbidity? New 4/17

Our hospital contracts are structured such that most hospitals are reimbursed based on all-inclusive diagnosis-related group (DRG) or per diem payments. In either case, the reimbursement rate covers all charges associated with an inpatient stay from the time of admission to discharge so it isn't feasible for hospitals to split inpatient claims.

Will a customer lose grandfathered status if they adopt COVID plan changes? New 5/5

COVID plan changes to provide greater coverage related to the diagnosis and/or treatment of COVID-19 such as waiving cost share for COVID-19 testing and related office visit, treatment, and telehealth will not cause a plan to cease to be a grandfathered health plan, provided that no other changes are made that would cause a loss of grandfather status.

SPECIAL ENROLLMENT

Update 9/2/21

This section updates UnitedHealthcare's voluntary special enrollment opportunity that was offered in response to COVID-19. The opportunity took place starting on March 23, 2020, was extended to April 13, 2020, and expired on Nov. 15, 2020.

The United voluntary special enrollment opportunity applied to fully insured group health plans but not self-funded group health plans. In the case of self-funded customers that did offer a special enrollment opportunity, UnitedHealthcare stop loss policies do not cover claims paid for members enrolled during a customer's voluntary special enrollment period. Self-funded customers with other stop loss vendors should discuss coverage for any changes with their stop loss vendor before adopting any changes.

PHARMACY COVERAGE

UnitedHealth Group is better together. We'd like to share a quick video clip from Optum and UnitedHealth Group collectively working together to make a difference in the COVID-19 crisis: https://www.optum.com/content/dam/optum3/optum/en/resources/videos-podcasts/optum-grateful-cv19web.mp4

Does UnitedHealthcare cover outpatient monoclonal antibody treatment? Update 4/1/2021

The FDA has issued emergency use authorization for 2 monoclonal antibody treatments. According to the CDC, monoclonal antibody treatments may be recommended by a member's provider if they test positive for COVID-19, and are at risk to get very sick or to be admitted to the hospital. This treatment can help the body respond more effectively to the virus.

A summary of coverage for monoclonal antibody treatment is below. Sign in to your online UnitedHealthcare member account for more details.

- **Exchange, Individual and Fully Insured Employer-sponsored plans:** For monoclonal antibody treatments, you will have $ 0 cost-share with network providers in outpatient settings through Mar. 31, 2021 and then will pay at plan benefits beginning April 1, 2021. Other COVID-19 outpatient treatments will be according to the member's benefit plan.
  Some self-insured health plans have different coverage benefits; if you have questions, please check with your human resources benefits team. Coverage for out-of-network services will be determined by your benefit plan.

- **Medicare Advantage plans: For monoclonal antibody treatments,** you will have $0 cost-share with in-network and out-of-network providers in outpatient settings through 2021. Medicare is paying for this treatment in 2021.

Will pharmacy coverage or treatment be impacted by COVID-19? Update 1/8/21

The Refill Too Soon edit was reimplemented on July 1 with one exception for Florida which requires the edit to be lifted through February 27, 2021. With COVID-19 restrictions being lifted, members now have the ability to work with their providers and pharmacies for medication updates as necessary. If there is a reason a member needs an early refill, requests can be made through our call centers.

The refill obtained will stay consistent with the standard days' supply previously filled by the member as allowed by their plan (e.g., 30- or 90-day supply).

We continue to monitor and will adjust our policies as appropriate.

Delivery options are available through Optum home delivery, which has no delivery fees for standard deliveries and through select retail pharmacies including Walgreens and CVS, who have waived delivery fees.

Can you comment further on the pharmacy supply chain and availability of medications? Can our employees still rely on mail order? Update 6/29

We have not seen delays in dispensing prescriptions related to COVID-19. This includes Optum-owned pharmacies, Optum Home Delivery, Optum Specialty, Optum Infusion Services, Avella, Genoa and Diplomat. We continue to stay closely connected to our other network partners and at this time do not anticipate any delays or supply issues related to prescriptions dispensed through retail pharmacy network.

Have any changes been made to the prior authorization program for medications covered through the pharmacy benefit? Are you extending authorizations? Update 6/29

Yes, we initially identified prior authorizations expiring for **select** medications between 3/16 and 4/30 and extended them for 90 days. We have also identified prior authorizations expiring between 5/1 and 5/31 and have also extended them for 90 days. Medications excluded from the automatic extensions include opioids, medications with defined treatment durations, such as treatment for hepatitis C, infertility, as well as other medications with upcoming coverage changes.

What is UnitedHealthcare approach to the medications Hydroxychloroquine and chloroquine for lupus and rheumatoid arthritis and for use for COVID-19? Update 6/29

In order to preserve a continued supply for the use of hydroxychloroquine for chronic indications such as systemic lupus and rheumatoid arthritis, UnitedHealthcare implemented quantity limits effective Mar. 28. Based on our ongoing monitoring of utilization, we continued to see a decrease in the number of prescriptions and removed the supply limit effective 5/22. Some network pharmacies and individual states have implemented their own dispensing policies. Members with a prescription for one of these products should consult with their pharmacist.

Have any changes been made to the launch date for the Medication Sourcing Expansion program? Update 1/8/21

In response to the COVID-19 public health emergency, UnitedHealthcare delayed the April 1 launch of Medication Sourcing Expansion (formerly Limited Supplier). This specialty pharmacy requirement directs hospitals to obtain certain specialty medications from a designated specialty pharmacy. The requirement was implemented on October 1, 2020.

Medication Sourcing Expansion program slides are available here.

How can members sign up for home delivery for their maintenance medications so they can stay at home? Update 6/29

The Centers for Disease Control and Prevention (CDC) encourages people to stay at home as much as possible. For UnitedHealthcare Optum Rx members that have pharmacy benefits, maintenance medications (medications taken regularly) can be received directly to their home through the home delivery benefit. Members can enroll online when logged onto myuhc.com and sign up for home delivery. Optum home delivery has no delivery fees for standard delivery.

Delivery options are also available through select retail pharmacies including Walgreens and CVS, who have waived delivery fees. Contact your pharmacy to determine if this is a service they provide.

Will UnitedHealthcare and OptumRx take steps to help members and prescribers adjust to supply chain distribution and find equivalent medications in case supply challenges do occur?
New 4/17

Yes, similar to when we experience ordinary course supply challenges, such as out-of-stock or recall situations, we partner with our members, prescribers and supply chain partners to identify alternatives and streamline the process to drive a faster turnaround and ensure our members have the therapy they need when they need it. We are also closely monitoring the supply chain to determine if we need to make any PDL coverage changes.

Will wellness credits roll over due to COVID-19? Update 10/6/21

There are no plans to carry over Wellness Credits at this time.

What specific items may wellness credits may be used for? Update 10/6/21

An employer can use wellness credits for COVID-19 testing for return to work, surveillance, at home testing and fees to vendors for this testing until October 17, 2021. These services will no longer be covered after this date.

Wellness credits for the purchase of COVID related safety items and premium credit reimbursement is covered until the end of the existing contract period, but no later than October 31, 2022.

Contact your UnitedHealthcare representative for full details on covered services and coverage expiration dates.

- **Employer Premiums for Health Insurance — ASO / FI c**ustomers can use through their wellness funds to pay for their medical premium.
- **Personal protective equipment (PPE) to prevent worker exposure** — Face masks, face covering, face shields, gloves.
- **Employee Screening** — Thermometers, Thermometer Gun, disposable Thermometers.
- **Personal Use & Cleaning Products** — Tissue and no-touch disposal receptacles; hand sanitizer products and no-touch dispensers; disinfectants: use products that meet EPA's criteria for use against SARS-Cov-2 and are appropriate for the surface. https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- **Cleaning Services of facilities**
- **Materials to COVID-proof Facility including signage**
- **COVID-19 testing** —in the employer's office for employees returning to work
- **Fees for vendor** — to conduct testing or collect test samples

Can gift cards be provided to member to incent members to get vaccinations for COVID-19? New 8/4/21

Yes, customers may use their wellness credits for gift cards to incent their employees to get the vaccine, if is available to all group members. A customer will want to work with their field account teams to get this set up and paid.

These gift cards may be considered a taxable benefit.

A contribution to an HSA would not be a taxable event.

Certain eligible services which qualify for reimbursement under wellness credits (as promoting improvement of physical or mental behaviors) are not qualified medical expenses under IRC § 213 (d) and thus reimbursement of them may be a taxable event for the plan participant.

These services will require communication to the customer/plan sponsor, to consult with their tax professional for further guidance on any reporting obligations.

- Gym equipment- onsite and offsite
    - Example: Bikes including Peloton, Elliptical, treadmill, pedometers, weights, Apple watch
- Gym memberships
- Online activity tracking and reward administration
    - Example: Paying a health and wellness vendor to track employee participation in wellness service.
- Relaxation equipment/services for onsite relaxation: Massage chairs, onsite massage, massage therapy, yoga
- Incentives related to health and wellness that are provided to encourage participation in wellness programs.
    - Examples: Entry fees to a wellness event (race) attire/gear for a wellness event, rental of equipment for wellness activity, water bottles, achievement awards, prizes for participation.
- Gift cards and cash

Will UnitedHealthcare support an employer who wishes to increase premium for their employees who are unvaccinated? Update 9/8/21

No. UnitedHealthcare does not support benefit differentials for vaccinated vs. unvaccinated individuals.

Can fully insured or self-funded customers use their Wellness Credits to pay for premium? Update 10/6/21

This must be discussed and approved with your UnitedHealthcare representative.

An employer can use wellness credits for premium credit reimbursement until the end of the existing contract period, but no later than October 31, 2022.

Contact your UnitedHealthcare representative for full details on covered services and coverage expiration dates

Can wellness credits be used for supplies like hand sanitizers and thermometers that are part of return to work or return to office programs? New 4/25

- Yes, UnitedHealthcare wellness credits may be used to purchase hand sanitizers, thermometers or other supplies use to provide a healthy and a safe workplace as employees are returning to the workplace.

Can a UnitedHealthcare Preventive Plan or other MEC-only plan that does not have stop loss add stop loss insurance? NEW 3/26

MEC plans are subject to the new legislation. However, many of these plans do not have stop loss insurance. It would be up to the plan sponsor, who is the fiduciary to speak with their consultant or broker to assess market solutions best for their respective plan situation.

Are testing and testing related visit claims covered for UnitedHealthcare Preventive Plan members? Update 10/17/21

The Preventive Plan does include waiver of cost sharing including co-payments, coinsurance and deductibles for medically appropriate COVID-19 testing and testing related visits at physician offices or telehealth in and out of network. Inpatient testing is out of scope. Testing must be ordered by a physician or appropriately licensed health care professional for purposes of the diagnosis or treatment of an individual member and provided at approved locations in accordance with CDC guidelines. Coverage is effective for claims as of March 18, 2020 and will remain in place through the public health emergency period, now January 15, 2022.

FULLY INSURED –BUSINESS DISRUPTION SUPPORT

The following questions and answers apply to medical coverage unless otherwise noted. For financial protection programs refer to the Specialty section.

Note: the public health emergency was extended through January 15, 2022.

May a fully insured group that missed UnitedHealthcare's special enrollment period in response to the COVID-19 National Emergency still offer a voluntary special enrollment? Update 11/16

- No. UnitedHealthcare sponsored a voluntary Special Enrollment Period (SEP) for our fully insured customers with employees seeking to change their benefit election in response to COVID-19. The SEP, however, is no longer available.
- The SEP took place March 23, 2020, was extended to April 13, 2020, and expired on Nov. 15, 2020. It created the opportunity for many individuals that previously waived coverage to enroll, and for others to revoke their existing election and/or make a new health coverage decision.
- UnitedHealthcare stopped offering its voluntary SEP effective Nov. 15, 2020. The SEP has sunset because it had been in place for several months, which allowed ample time for individuals who had previously waived coverage prior to COVID-19 to enroll in coverage. In addition, many of our fully insured customers are now engaged in their annual open enrollment periods. Thus, the voluntary period is no longer needed.

Does the expiration of the UnitedHealthcare voluntary SEP affect the rights of individuals to enroll under HIPAA when certain life events take place or other group health plan coverage is lost? Updated 11/12

No. The expiration of the UnitedHealthcare Voluntary SEP does not affect rights an individual has to enroll under the HIPAA portability special enrollment provisions. Individuals are provided with special enrollment rights when certain family, job or other events take place so long as they meet applicable portability requirements.

Under HIPAA portability, an individual is provided with special enrollment rights when one of the following special life events occurs. A member is allowed special enrollment when there is a:

- Birth of newborn
- Legal Adoption
- Placement for Adoption
- Marriage

Special enrollment is also available when there is a:

- Loss of coverage due to:
  - Job Change
  - Reduction of hours
  - Loss of employment (not due to gross misconduct or failure to pay premiums)
  - Loss of Spouse coverage
  - Dropping of coverage due to stop of employer contributions to coverage
  - Loss of Medicaid, CHIP eligibility or when an individual becomes eligible for state premium assistance.

If a fully insured employer reduces hours for part or their entire workforce in response to the COVID-19 public health emergency can the company continue to cover those employees? Update 2/1/2021

For health plan products: UnitedHealthcare is temporarily relaxing its requirement that employees be actively working to be eligible for coverage and will allow you to cover your reduced hour employees, as long as you pay the monthly premium. If the employee is on a customer-approved leave of absence/furlough and the customer continues to pay required medical premiums, and the employee was eligible for and enrolled in coverage before the absence/furlough, the coverage will remain in force the later of the end of the public health emergency, or no longer than 20 consecutive weeks after the public health emergency for non-medical leaves (i.e., temporarily laid off) or no longer than 26 consecutive weeks for a medical leave. This applies to Oxford and Level Funded (All Savers) customers. Dental and vision follow the same furlough approach as medical. Coverage may be extended, if required by local, state or federal rules. Please note that you must offer this coverage on a uniform, non-discriminatory basis.

For Life, Accidental Death & Dismemberment (AD&D), Critical Illness Protection (CIPP), Accident Protection (APP), Hospital Indemnity Protection (HIPP) products: As long as the employer continues to pay the monthly premium, coverage due to an approved layoff, is outlined in the Termination of Covered Person Insurance or Termination of Covered Employee Insurance section of these policies. It may vary by customer. Refer to your actual Certificate(s) of Coverage for specifics on your plan(s).

By way of reference, UnitedHealthcare's standard language (which applies to most customers) for all these products allows for coverage to continue due to an approved layoff for up to 3 months from the date he/she stopped active work.

For Short Term Disability (STD), Long Term Disability (LTD) products: As long as the employer continues to pay the monthly premium, coverage due to an approved layoff is outlined in the Termination of Covered Person Insurance section of these policies. It may vary by customer. By way of reference, UnitedHealthcare's standard language allows for coverage to continue due to a temporary layoff until the end of the month following the month in which the layoff began.

Is UnitedHealthcare considering off-renewal premium changes for small businesses that may be financially impacted?

UnitedHealthcare is not changing premium rates off renewal for small business.

Can employers use credit cards to pay premiums?

No, UnitedHealthcare is unable to accept credit card payments for group premium this time.

Will renewal rate actions be delayed as a result of the COVID-19 national emergency?

Renewals and all necessary information will be released on a timely basis.

Will UnitedHealthcare allow fully insured clients to continue to offer medical benefits to furloughed or with reduced hours due to COVID-19? Update 10/5

Yes, we will temporarily allow it if the plan sponsor continues to pay the premiums and offers the option to all furloughed employees on an equal basis.

in order to stay consistent with the end of the emergency period– UnitedHealthcare offers customers the ability to extend furloughed non-medical leave employees to the end of the emergency period OR 20 weeks whichever is later. There is no change to medical leave.

Are furloughed employees eligible for fully insured plans? Update 7/31

UnitedHealthcare will allow employers to extend coverage for furloughed employees (employees whose hours have been reduced or eliminated but whose employment has not been deactivated) for 20 weeks.

This coverage extension only applies if:

- Premiums are paid to UnitedHealthcare for the continued coverage; and
- The employee was eligible and enrolled for coverage before the furlough began; and
- The furlough starts prior to the end of the Public Health Emergency; and
- The continuation is offered to furloughed employees on a uniform, non-discriminatory basis.

There is no change to UnitedHealthcare's policy on continued coverage for an employee on an employer-approved medical leave.

Note coverage may be extended longer, if required by local, state or federal rules.

Can an employer reduce its employer contributions to premium during a furlough? New 4/17

No, the same employer contribution level must apply to all members enrolled in the same benefit plan.

Are customers able to continue employee health benefits if *part of* the workforce is laid-off in response to the COVID-19 crisis? Update 2/1/2021

in order to stay consistent with the end of the emergency period– UnitedHealthcare offers customers including Oxford customers the ability to extend furloughed non-medical leave employees to the end of the emergency period OR 20 weeks whichever is later. There is no change to medical leave.

Temporarily we will allow employers to continue coverage for employees who were eligible for and enrolled in coverage prior to the reduction in workforce, if the plan sponsor continues to pay its premiums and offers the option to all employees on an equal basis. However, it is important to make a distinction between individuals whose employment is terminated (often "laid-off" means terminated) versus individuals still employed but experiencing a temporary reduction of hours but remains employed. In those situations where the individual continues to be employed but may have seen a reduction in work or been put on furlough as a result of COVID-19 crisis, we will temporarily not enforce insurance contractual requirements that mandate active at work status or minimum hours where we continue to receive full premium and the employer applies this approach to all such employees on an equal basis.

If the employee is on a customer-approved leave of absence/furlough and the customer continues to pay required medical premiums, the coverage will remain in force the later of the end of the emergency period, or:

- No longer than 20 consecutive weeks for non-medical leaves (i.e., temporarily laid off)
- No longer than 26 consecutive weeks for a medical leave

Note coverage may be extended, if required by local, state or federal rules.

However, if an employee is laid off/terminated, normal termination rules apply.

Note: ASO clients can set their own timeline for continuation for furloughed employees.

If a fully insured employer *reduces hours for part or their entire workforce* in response to the COVID-19 national emergency can the company continue to cover those employees? Update 4/16

UnitedHealthcare is temporarily relaxing its requirement that employees be actively working to be eligible for health coverage and will allow you to cover your reduced hour employees, if the employers pay the monthly premium. The employer must offer this coverage on a uniform, non-discriminatory basis.

Coverage may be extended, if required by local, state or federal rules.

Note: ASO clients can set their own timeline for continuation for furloughed employees.

Do the days on furlough count toward the waiting period and would the member be eligible to enroll while on furlough. If not, do the days they are on a waiting period prior to the furlough count and they just need to meet the remainder once they return to work? New 4/27

Yes, the furloughed or LOA days do count towards the waiting period, so long as the employee is not laid off/terminated.

If a member is collecting unemployment benefits does that effect their ability to stay on the coverage as an active employee through the Oxford plan? Update 5/13

No, some employers are paying for health care for their furloughed employees. This should not impact unemployment benefits.

Are customers able to continue employee health benefits if *the entire* workforce is laid off in response to the COVID-19 crisis? New 3/25

There needs to be one active employee for a group health plan to continue to exist. Normal termination rules apply.

If the group terminates employees in the middle of the month as a result of COVID-19, will fully insured coverage extend for the terminated employees until the end of the month? New 4/5

If premiums have been remitted for the month, coverage will continue through the end of that month or the date of event depending on the eligibility rules under your policy.

If the group terminates employees in the middle of the month as a result of COVID-19, will fully insured coverage extend for the terminated employees until the end of the month? New 4/5

If premiums have been remitted for the month, coverage will continue through the end of that month or the date of event depending on the eligibility rules under your policy.

Will you waive any rehire waiting period for re-hired employees whose job was ended due to COVID-19? Update 11/23

Yes. UnitedHealthcare does not set or administer any waiting periods. As the employer, you have the option to waive the waiting period and follow existing eligibility rules with respect to date of event or first of month.

Can UnitedHealthcare waive participation requirements during this time for new groups that need insurance? For example: if 2 out of 5 employees that are enrolling, so under 50% on participation. New 4/5

No. New groups will be subject to normal rules for acceptance - binder checks, participation requirements, etc.

What continuation of coverage applies if my plan is fully insured and one or more employees are terminated as a result of COVID-19?

Standard COBRA and state continuation protocols apply.

If I terminate employees in the middle of the month as a result of COVID-19, will my fully insured coverage extend for the terminated employees until the end of the month?

If premiums have been remitted for the month, coverage will continue through the end of that month.

What if employees are terminated and either they do not elect COBRA or there is no COBRA available because the group health plan has been discontinued?

If employees are terminated and either they do not elect COBRA or there is no COBRA available, the employee has the opportunity to enroll in the Exchange in their state. Both small employers and individuals must elect Exchange Market Place Coverage within 60 days of their termination, or they will have to wait until the next open enrollment period.

UnitedHealthcare offers individuals a range of individual health insurance plans. Interested people may contact (800) 827-9990 to speak with an advisor who can assist. They can also visit https://www.healthmarkets.com to apply directly.

If my group's enrollment drops by more than 10% as a result of the COVID-19 National Emergency, will my rates and premiums on my fully insured plan be subject to change? NEW 4/3

Small group ACR rates will not be adjusted **at the time of new group coverage or** off renewal.

For large group, for the present time, if the loss of enrollment is a result of the COVID-19 situation, rates and premiums will not be adjusted **at the time of new group coverage or** off renewal.

If a group gets a premium extension approved, would UnitedHealthcare continue to pay for any medical claims in those extension periods and not seek recoupment of paid claims should the group be termed for non-payment of premiums at some point? New 4/16

UnitedHealthcare will continue to pay claims during the grace period extension. Recoupment of the claims will depend on the termination date and the termination provisions in the group contract. If the group has termination as of the paid through date vs. end of grace – those claims will be recouped.

Will UHC continue to pay commissions on those groups in a premium extension? New 4/16

Commissions will be paid when the premium is paid.

- If a customer uses an extended "grace period", the commissions or service fees will be paid when the customer makes the delayed payment.
- Base commissions and service fees will be reduced commensurate with the reductions in membership experienced by the employer groups.
    - If premiums decrease, compensation based as a percent of premium will decrease.
    - If employment decreases, compensation based on a per-employee-per-month basis will decrease.

ASO – BUSINESS DISRUPTION AND STOP LOSS SUPPORT

PLEASE REFER TO OTHER SECTIONS FOR ADDITIONAL INFORMATION.

Does the recent IRS Rule and Notices on FSAs, DCAP, and 2020 enrollments mean that the employer may allow their employees to make any calendar year 2020 election changes to their current medical plan? Update 11/20

For self-funded customers, eligibility and enrollment decisions under their Plans are the customers to make. As the third-party administrator, UnitedHealthcare will perform its administrative services in accordance with these eligibility determinations. With respect to IRS Notice 2020-29 allowing 2020 calendar year election changes, as the stop loss carrier for self-funded plans, UnitedHealthcare will not cover claim payments of any plan members enrolled outside of annual open enrollment or a HIPAA qualifying life event.

For FSA or HRA/HIA accounts, for employers may allow employees to allow prospective changes. In addition, based on the Notice, changes to the dependent care FSA (DCAP) are also permitted.

From a stop loss perspective, will UnitedHealthcare stop loss support calendar year changes to health plans that are mentioned in the recent Notice 2020-29 or Notice 2020-33? New 5/29

With respect to IRS Notice 2020-29 allowing 2020 calendar year election changes, as the stop loss carrier for self-funded Plans, UnitedHealthcare will not cover claim payments of any Plan members enrolled outside of annual open enrollment or a HIPAA qualifying life event.

Are self-funded clients required to follow the different rules on COVID-19?

Self-Funded clients are generally not impacted by state laws and regulations but instead are required to follow federal standards under ERISA and other federal legislation such as The Families First Coronavirus Response Act (HR 6201). If a self-funded client chooses to follow the state regulations, please contact your Account Executive to work through UnitedHealthcare's ability to support the request.

What should a self-funded employer consider relative to stop loss risk, plan documents, cost projections or other implications concerning COVID-19?

Self-funded clients are considered the plan fiduciary. As such, they are the final authority on plan design provisions and should consult with their professional advisors.

What is the impact to UHC stop loss for changes to Virtual Visits or telehealth including telehealth OT, PT and ST? New 4/11

No impact to stop loss.

Will UnitedHealthcare Insurance Company (UHIC) and UHIC-BP stop loss policies follow the underlying plan document to determine eligible, or not covered, stop loss insurance claims? Update 4/5

Plans that automatically include coverage for services required by federal legislation (e.g., Family First Coronavirus Response Act) and follow UnitedHealthcare's recommended-standard option will automatically have eligible claims considered eligible charges under our stop loss policy.

For customers that choose to "opt-In" for treatment to be covered at 100% in line with our fully insured policy, we will cover the services under our stop loss. We will not adjust the premiums (ISL and/or ASL), the ISL deductible or aggregate claim pick.

Eligibility guidelines under our stop loss policy will follow the underlying plan design eligibility guidelines. This includes Leave of Absence, Temporary Layoffs, Active at Work Provisions and COBRA. Our stop loss will also accommodate the Plan's waiver of rehire waiting periods should the Plan choose to change its eligibility rules to do so. The one exception to this provision is that we will NOT agree to coverage for newly enrolled individuals due to any "Special Enrollments".

For ASO groups that experience a change in lives greater than 10% driven by COVID, what will the impact be to re-rating during the event? New 4/14

For ASO customers that temporarily experience a reduction in force due to COVID-19, UnitedHealthcare will not adjust the administrative fees. We will evaluate the enrollment level upon renewal to determine if any change in administrative fees is required. Fees will not be adjusted mid-contract period due to layoffs.

For ASO groups that experience a change in lives greater than 10% driven by COVID 10, what will the impact be UHC/UHC-BP's stop loss premium rates, individual stop loss deductibles and aggregate claim picks? New 4/14

Our decision for this time is that we will not adjust premium rates, stop loss deductibles or claim picks until the next plan anniversary. However, we are reserving the right to modify that position after further review on or after June 30, 2020.

In all circumstances, we will rerate policies at their normal anniversary dates.

Will UnitedHealthcare allow continuation coverage for self-insured plans on UNET and UMR even if they go under 100 lives? New 4/5

Yes, UnitedHealthcare will not enforce minimum participation (FTE count) provisions for customers during periods of furlough.

If a client reduces the hours of part of their workforce in response to the COVID-19 National Emergency, can a self-funded company continue to cover those employees?

Yes. If UnitedHealthcare is your stop loss carrier, as long as you continue to pay administrative fees and claims costs, along with your stop loss premium, you may continue to cover reduced-hour employees even though they are not actively at work during the emergency. Please note that you must administer the plan on a uniform, nondiscriminatory basis. You may not choose only certain people for whom you continue to pay claims.

All clients with a third party stop loss carrier are responsible for confirming with their stop loss insurer that their stop loss coverage aligns with their plan coverage decision as well as any questions about covering reduced hour employees who are not actively at work for some period.

Although we are communicating our intentions with Optum Stop Loss, **we still require clients to confirm their stop loss coverage directly with Optum Stop Loss.**

How will your stop loss handle timely filing for stop loss claims? NEW 3/27

UHIC and UHIC-BP will ensure coverage for any eligible stop loss claims if the underlying plan covers the claims

Clients with third party stop loss should contact their stop loss insurer for a response.

What about continuation of coverage for self-funded plans?

If your group is subject to COBRA, as long as one person remains actively employed, terminated employees may elect to continue coverage under COBRA under the normal notice and election procedure. If UnitedHealthcare is not your stop loss carrier, be sure to check with your stop loss carrier about any rules it may have regarding minimum enrollment of active employees for stop loss coverage. If the plan has no active employees, the plan is terminated, and COBRA is not an option. In that case, employees would have a special enrollment period to enroll in individual coverage. You may contact Health Market (800) 827-9990 or https://www.healthmarkets.com for individual market coverage options.

Although we are communicating our intentions with Optum Stop Loss, **we still require clients to confirm their stop loss coverage direct with Optum Stop Loss.**

What is the process for a self-funded client who declines to cover the test and test-related expenses at no cost share?

Based on federal legislation passed on March 18, all plans are required to cover these services.

How will your stop loss handle timely filing for stop loss claims?

UHIC and UHIC-BP will ensure coverage for any eligible stop loss claims if the underlying plan covers the claims. Clients with third party stop loss should contact their stop loss insurer for a response.

Is there a requirement for the SPD to be updated prior to making plan changes to support COVID-19? Update 5/31

Generally, the changes we are making to support zero cost share for the diagnosis and testing associated with COVID-19 offer a better benefit. As a general rule, if the changes are plan enrichments and not reductions then such changes do not need to be made immediately, there is 210 days from the end of the plan year to issue the changes.

Self-funded customers should continue to monitor their SPDs for required changes including stop loss language and, as always, validate their approach with legal counsel.

Recent guidance requested that a notice be sent for employers to inform their employees of any temporary changes to their plans due to the national emergency. Therefore, UnitedHealthcare has

created a notice for employers to inform members of changes to benefits due to the COVID-19 national emergency as required by law. This alternative notice is allowed in place of changes to plan documents or material modifications.

Are you offering fee holidays?

No, we are not waiving administrative fees nor stop loss premium. Our contracts include standard provisions for late payment.

Are furloughed employees eligible for fully insured plans? Update 10/5

in order to stay consistent with the end of the emergency period– UnitedHealthcare offers customers the ability to extend furloughed non-medical leave employees to the end of the emergency period OR 20 weeks whichever is later. There is no change to medical leave.

UnitedHealthcare is temporarily allowing employees that were eligible for and enrolled in coverage before an absence or furlough to remain eligible for coverage during periods of temporary layoffs and/or reduction in hours. UnitedHealthcare is reliant on employers to notify us of employment status of their employees. If the employer chooses to pay for their coverage, then you would not notify us of a coverage change and furloughed employees would remain on the plan temporarily.

If the employee is on a customer-approved leave of absence/furlough and the customer continues to pay required medical premiums, the coverage will remain in force the later of the emergency period, or:

- No longer than 20 consecutive weeks for non-medical leaves (i.e., temporarily laid off)
- No longer than 26 consecutive weeks for a medical leave

Note coverage may be extended, if required by local, state or federal rules.

As a self-funded plan administrator, if I want to cover COVID-19 at 100% how should I proceed? Update 3/24

UnitedHealthcare is committed to supporting its customers by honoring the following actions that our stop loss policyholders may take considering the COVID-19 crisis. If UnitedHealthcare is your stop loss carrier:

- **Deductibles, Copays, and Cost-Sharing:** Policyholders who decide to waive the cost of deductibles, copays, and cost-sharing for COVID-19 diagnostic testing, and the office visit, ER visit, or urgent care visit associated with the test, for covered participants will be allowed to apply these costs as eligible expenses under their stop loss policy.

- **Telemedicine and Virtual Visits:** Policyholders who decide to waive cost-sharing for telemedicine and Virtual Visits for covered participants will be allowed to apply these costs as eligible expenses under their stop loss policy, without any prior notification.

- **Early Rx Refills:** Policyholders who decide to allow covered participants to receive early prescription refills to ensure they have a 30-day supply will be allowed to apply these costs as eligible expenses under their stop loss policy, without any prior notification.

These changes are effective immediately. We hope these actions make it easier for our policyholders to provide for the health and safety of their plan participants. If a self-funded customer wishes to expand benefit coverage beyond the bullets above, adjustments to rate may be required.

If UnitedHealthcare or UMR is your administrator, but your stop loss policy is with an alternative carrier, check with the carrier for guidance.

Can an ASO group have a special enrollment and, if so, are their limitations to what may be offered? New 4/14

ASO client can hold a SEP; however, any current member must stay with existing plan, unless

- If the client chooses to add a leaner plan design (higher deductible, lower coinsurance or otherwise actuarial value less than existing plans) then existing members can elect to buy down, but only to that plan.
- New members can pick from any of the plan designs offered, however new members added will not be covered under stop loss (if stop loss is offered).

What is call center response to members of self-funded groups that call in and asking about benefits? New 4/28

All plans are federally mandated to waive costs for COVID-19 testing and the testing-related visit, which includes but not limited to office visits and Virtual Visits specific to COVID-19 testing. Individual plans and states have different requirements specific to COVID-19-related treatments and other telehealth services. With careful consideration, UHC partnered with employer groups to review changes in coverage. We are in a rapidly changing environment and updates to plan benefits are still occurring.

What is UnitedHealthcare's intent to comply with all requirements of the CARES Act? New 6/26

The CARES Act and the related guidance create both permissive, as well as mandatory, requirements.

UnitedHealthcare's administration of self-insured plans is aligned with the requirements of the CARES Act including supplementary guidance provided from time to time by applicable regulatory agencies.

However, self-funded plans have some discretion in what is implemented/administered.

What language should we to use in a SMM regarding the COVID vaccine coverage? New 12/11

Since there is not a material modification to a customer's plan based on the addition of the COVID-19 vaccine, no SMM is required. The vaccine falls under the ACA preventive services category.

FINANCIAL, BUSINESS CONTINUITY AND REPORTING

Will renewal rate actions be delayed as a result of the COVID-19 national emergency?

Renewals and all necessary information will be released on a timely basis.

If a self-funded customer has tiered administrative fees based on enrollment, and they experience a change in covered lives due to layoffs or furloughs related to COVID-19, will their administrative fees change?

No, for the next 60 days, we will not change any administrative fees based on a change in enrollment.

If a new customer, effective April 1 or May 1 has a change in enrolled census due to layoffs associated with COVID-19, will their quoted rate change? Updated 4/7

Small group ACR rates will not be adjusted **at the time of new group coverage or** off renewal.

For large group, for the present time, if the loss of enrollment is a result of the COVID-19 situation, rates and premiums will not be adjusted **at the time of new group coverage or** off renewal.

Can fully insured groups that are scheduled to have open enrollments in March or April during business shutdowns and/ or have effective dates during these shutdowns, push open enrollment out past effective date when employees are back to work?

In order to ensure no disruption in benefits to members at this critical time, UnitedHealthcare will automatically enroll members to their existing 2019 plan option updated for 2020 rates and benefits. UnitedHealthcare will allow the group policyholder up to thirty (30) days post renewal to advise us of changes. In some limited instances, the 2019 plan option may no longer exist (e.g. plan discontinuance). In such instances we will map groups and enrollees to the closest equivalent plan options.

If a fully insured employer reduces hours for part or their entire workforce in response to the COVID-19 national emergency can the company continue to health benefits for those employees? Update 4/16

For health plan products, UnitedHealthcare is temporarily relaxing its requirement that employees be actively working to be eligible for coverage and will allow you to cover your reduced hour employees, if you pay the monthly premium. Please note that you must offer this coverage on a uniform, non-discriminatory basis. However, if an employee is terminated, the normal termination rules apply.

Coverage may be extended, if required by local, state or federal rules.

Note: ASO clients can set their own timeline for continuation for furloughed employees.

Are customers able to continue employee health benefits if *part of* the workforce is laid-off in response to the COVID-19 crisis? Update 10/17/21

in order to stay consistent with the end of the emergency period– UnitedHealthcare offers customers the ability to extend furloughed non-medical leave employees to through the public health emergency period OR 20 weeks whichever is later. There is no change to medical leave.

Temporarily will allow employers to continue coverage for employees who were eligible for and enrolled in coverage prior to the reduction in workforce, if the plan sponsor continues to pay its premiums and offers the option to all employees on an equal basis. However, it is important to make a distinction between individuals whose employment is terminated (often "laid-off" means terminated) versus individuals still employed but experiencing a temporary reduction of hours but remains employed. In those situations where the individual continues to be employed but may have seen a reduction in work or been put on furlough as a result of COVID-19 crisis, we will temporarily not enforce insurance contractual requirements that mandate active at work status or minimum hours where we continue to receive full premium and the employer applies this approach to all such employees on an equal basis.

If the employee is on a customer-approved leave of absence/furlough and the customer continues to pay required medical premiums, the coverage will remain in force the later of January 15, 2022, or:

- No longer than 20 consecutive weeks for non-medical leaves (i.e., temporarily laid off)
- No longer than 26 consecutive weeks for a medical leave

Note coverage may be extended, if required by local, state or federal rules.

However, if an employee is terminated, the normal termination rules apply.
Note: ASO clients can set their own timeline for continuation for furloughed employees.

Are customers able to continue employee health benefits if *the entire* workforce is laid off in response to the COVID-19 crisis? New 3/25

There needs to be one active employee for a group health plan to continue to exist. Normal termination rules apply.

Does UnitedHealth Group have a business preparedness (continuity) plan?

Yes. The plan addresses business continuity strategies for all forms of events natural and man-made including pandemics. The strategies focus on our critical business functions and planning for the worst-case scenarios so that we can react quickly and efficiently adding value to our business and customers, members and other stakeholders through effective risk reduction, compliance with industry, contractual and regulatory standards, and safeguarding our operations and assets.

How is UnitedHealth Group supporting clinical personnel to help on the front line? New 4/13

Our priority is to make sure that your members have access to medications, treatments, office time and testing as appropriate. The second priority is making sure that we have people on the phone lines, working from home, so that they can help members navigate system. The final and most important thing is that we have 100,000 physicians across the company, across the world, who are seeing more than 30 million patients. We need to make sure that these physicians, as well as the 1.2 million providers in our U.S. network, are healthy and capable to serve. So, we are making sure there is a pipeline of personal protective equipment (PPE) available and protocols in place so that clinicians can safely see patients.

Beyond roles that are directly involved in care, we have also redirected cafeteria staff to serve meals in some communities to people with the greatest need and in other communities to the families of the heroes we have on front line taking care of people on a regular basis.

CLAIMS AND APPEALS

If a plan does not have out-of-network (OON) benefits, will the plan pay for COVID-19 OON care? New 5/12

Yes, for a plan that doesn't have OON benefits but related to the COVID treatment during this COVID emergency period, we would pay at the network (INN) level including inpatient care.

If a member is not feeling well and has some symptoms but is not tested for COVID-19 (for example they receive a flu test) and the visit and test are not coded as COVID-19, how will the care be paid? New 4/20

The provider should bill for the services conducted. In this case there is no COVID-19 testing diagnosis or test codes billed or COVID-19 diagnosis code associated with the care, then it would be paid based on the members normal benefit plan and standard cost share applies.

Are items like Pedialyte and Gatorade covered as a COVID-19 test-related expense? New 4/20

No. These are not covered under medical benefits.

Do UnitedHealthcare commercial out of network programs satisfy the requirement in the CARES Act that states "the plan may negotiate a rate with a provider for less than the cash price"? New 4/20

Yes. CARES Act provision (3202) requires plans to reimburse providers for COVID-19 tests at the contract rate negotiated before the COVID-19 emergency, or, if there is no contract, a cash price posted by the provider as listed on a public internet website, or the plan may negotiate a rate with the provider for less than the cash price.

Where UnitedHealthcare has an out-of-network program in place, the price may be negotiated based on the rule.

Will standard programs apply to OON claim processing, e.g., R&C cutbacks, MNRP, shared savings etc.? Update 7/24

Yes, standard OON programs apply. Any plan that has R&C would be managed on the back end and we would negotiate up to posted cash price. If that is not available, the standard OON reimbursement would apply.

Does UnitedHealthcare require a COVID-19 test claim to be present for a testing-related office visit claim to pay at no member cost share? Update 5/12

A COVID-19 diagnosis code or COVID-19 test code is required on the claim to waive cost share.

If the presence of a COVID-19 test claim is not required, then will only a COVID-19 diagnosis code on the claim pay at no member cost share? Update 5/12

A COVID-19 diagnosis code or COVID-19 test code is required on the claim to waive cost share.

If there is a COVID-19 test claim, but the testing-related office visit does not have a COVID-19 diagnosis code, would the office visit claim be paid at no member cost share? Update 5/12

To waive member cost share, a COVID diagnosis code or COVID-19 procedure code must be on the claim.

If a COVID-19 testing or treatment diagnosis code is required for a testing-related office visit claim and there is not one present on the claim, will the provided need to submit a revised claim with a COVID-19 diagnosis for the claim to pay at no cost share for the member? Update 5/12

Yes

How are appeals team handling claims that do not have appropriate COVID-19 codes on the claim? Update 6/15

UnitedHealth Group has waived member cost-sharing for COVID-19 testing and treatment from the onset of the pandemic. Some members received bills early on when there were not yet specific COVID-19 billing codes and during a period in which code adoption was first taking place. We are waiving those charges and have been proactively evaluating claims from early February and March to ensure claims were paid correctly and cost-sharing was appropriately waived. We urge members who may have concerns about charges to call us to resolve any issues.

If there is no indication of COVID in the diagnosis or procedure codes, and no admission for COVID or subsequent COVID test within a reasonable time frame – the claim will pay according to plan benefits and member cost share may apply.

We are proactively reviewing claims using specific clinical guidance and 3 CDC identified COVID symptoms as a guide for handling upfront for claims with dates of service 2/4 to 3/31.

Any appeals are being reviewed through an exception process on a case by case basis for those claims. Providers have been sent information and coding and process information is posted on uhcprovider.com

Can members submit claims if they must pay upfront for a test or test-related visit? New 5/15

Care providers are responsible for submitting accurate claims in accordance with state laws, federal laws and UnitedHealthcare's reimbursement policies. Regardless of upfront payment, the provider's office should be submitting the claims. Therefore, members would not submit receipts for UnitedHealthcare to process.

How does the Final Rule change timing for claim submission? Update 7/13

The Final Rule mandates that plans disregard the Outbreak Period for purpose of applying certain plan deadlines, including the timeline for submitting a claim for benefits.

Prior to the Final Rule, the timeframe for submitting a claim to a group health plan was set by the terms of the plan and each day from the date of service to the date the claim was submitted was counted. Many plans gave participants 365 days to submit a claim. Under the final rule, time between March 1, 2020 and the end of the Outbreak Period is not counted. Assume that a member received services on March 1, 2020 (the effective date of the Final Rule) but did not file the claim until

more than a year later, April 1, 2021. Under the final rule, the claim is valid even though it was not filed until April 1, 2021. The claim is timely because time from March 1 through the end of the Outbreak Period, is not counted for purposes of determining whether a claim is timely.

UnitedHealthcare is updating EOBs and appeal letters for claims and appeal decisions we issue during the Outbreak Period identified in the DOL's final rule issued May 4, 2020. The EOB and appeal letters will advise claimants that the deadline for subsequent reviews are extended until further notice and encourage members to seek additional information and guidance from their plan/employer. When claims and appeals are submitted during the Outbreak Period —even though members are not obligated to do so — UnitedHealthcare will continue to render a claim or appeal decision within normal timeframes. UnitedHealthcare is using that opportunity to advise members about the extensions. Our systems are operationalized to compute and apply the correct tolling period to determine timely filing for claims, appeals and reviews when submitted.

How does the Final Rule change timing for FSA or HRA claim submission? New 6/6

Since they are ERISA-governed plans, the Final Rule requires that the time period to submit Health Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs) claims be extended in accordance with the Final Rule. This Final Rule affects the deadline to submit reimbursement requests under a Health FSA or HRA which are generally a few months after the end of the plan year. For example, if a calendar year Health FSA plan had a runout period that ended on April 30, 2020, this means the plan could not require that participants forfeit any remaining balance during the Outbreak Period. Plans may need to flag claims that were previously denied for failure to timely file claims or appeals. Dependent Care FSAs are not ERISA plans and are not subject to the Final Rule.

APPEALS

How does the final rule affect appeals for adverse determinations and filing a request for external review? Update 7/13

Prior to the rule, a member must be given at least 180 days within which to appeal an adverse benefit determination. The Final Rule mandates that plans disregard the Outbreak Period for purpose of applying certain plan deadlines including the date on which a claimant must file an appeal of an adverse benefit determination under the plan and the timeline for filing a request for external review and for perfecting such a request.

UnitedHealthcare is currently in the process of updating our EOBs and appeal letters for claims and appeal decisions we issue during the Outbreak Period identified in the DOL's final rule issued May 4, 2020. The EOB and appeal letters will advise claimants that the deadline for subsequent reviews are extended until further notice and encourage members to seek additional information and guidance from their plan/employer. When claims and appeals are submitted during the Outbreak Period —even though members are not obligated to do so — UnitedHealthcare will continue to render a claim or appeal decision within normal timeframes. UnitedHealthcare is using that opportunity to advise members about the extensions. Our systems are operationalized to compute and apply the correct tolling period to determine timely filing for claims, appeals and reviews when submitted.

REPORTING

Can UnitedHealthcare provide COVID-19 claims reporting?

UnitedHealthcare is working on reports related to COVID-19 and will make those available as appropriate.

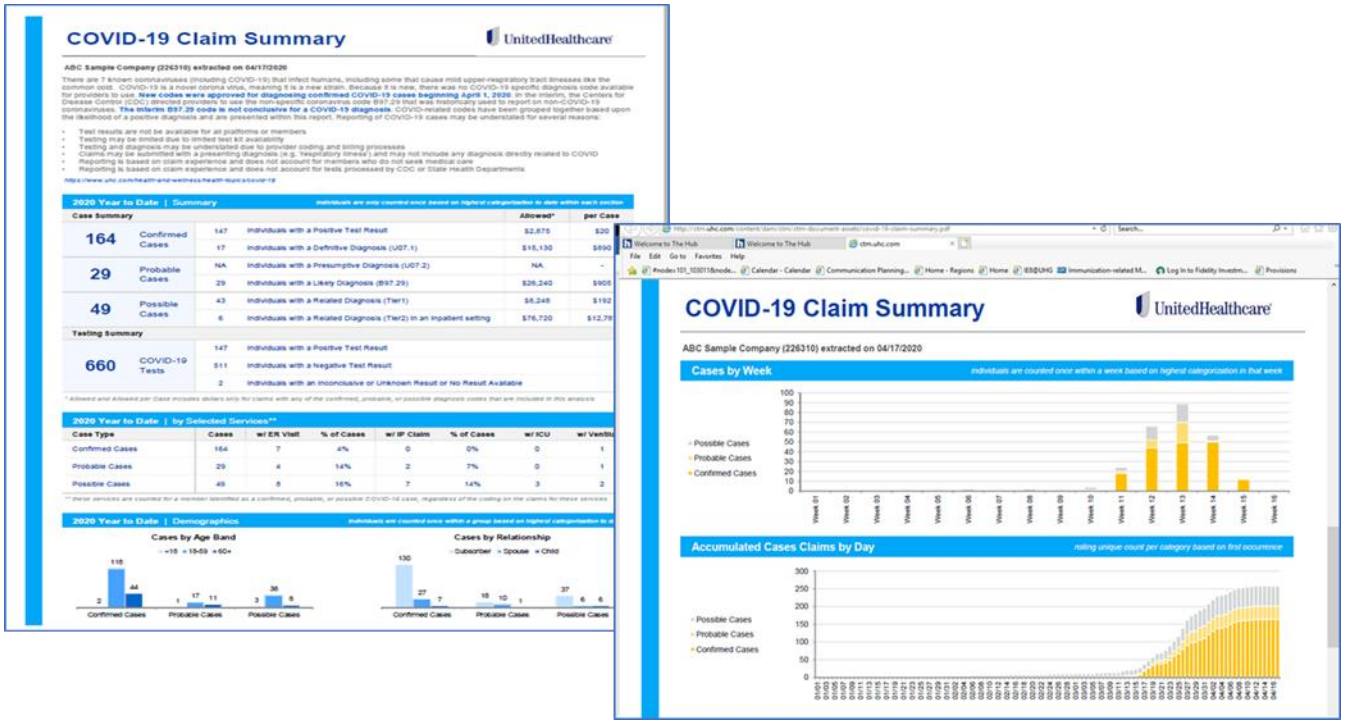
How do customers get COVID-19 reports? Update 4/29

UnitedHealthcare account executives are in the process of sending out the first client specific reports to clients with 100+ employees. The customer can request future reports by working with their SCE/SAE based on how frequently they would like their report. Additional data will be added as more claims are processed.

UnitedHealthcare COVID-19 Prevalence and Cost Report includes:

- Claims Reporting – prevalence, testing, costs
- Expanded coding categories, which shows a more complete view of the disease
- Key utilization metrics (admissions, emergency room, ICU, ventilators)
- Interactions – Advocacy events related to COVID
- Virtual Visits – Utilization and wait times
- Member Call Data – All conversations related to COVID

Sample Report Below



Why are no costs shown in the testing section of the report? New 5/2

The testing data are lab results and not claims data.

Can we share specific member PHI? New 5/2

Per UnitedHealthcare privacy office guidance, UnitedHealthcare is unable to share COVID personal health information (PHI) externally.

Can an employer ask for a customize the report? New 5/2

At this time, we cannot customize the report.

PAYMENT INTEGRITY

The health of our members and the safety of those who deliver care are our top priorities. COVID-19 is a rapidly evolving national health emergency, and UnitedHealthcare is working closely with national, state and local health organizations. As an organization we are taking action and providing resources to support providers during this challenging time.

UnitedHealthcare will reimburse all COVID-19 testing and treatment in accordance with applicable law, including the CARES Act.

How are we are enhancing our fraud, waste and abuse programs to address specific actions related to COVID? New 4/14

Our Payment Integrity fraud, waste, abuse and error (FWAE) processes are based on historical knowledge and factors that have been identified as associated with or indicative of a higher risk for FWAE. Leveraging this process, Payment Integrity has designed and deployed additional analytics based on anticipated aberrant behavior related to COVID.

As the COVID claim and billing history matures, these analytics will continue to be edited or enhanced, reflecting the traditional model focused on historical knowledge. In addition, we are coordinating with national and state agencies and regulators to address emerging COVID fraud schemes.

How are we helping to control balance billing for out-of-network (OON) office visits associated with the COVID-19 TESTING and testing-related visits at Physician Offices? New 4/14

Payment Integrity standard process includes monitoring for aberrant and / or egregious billing for both in and out of network providers.

The potential for Member balance billing will be monitored and addressed through our standard process, which includes, but is not limited to, member communication, and provider and member notifications around balance billing rules.

How are we protecting members from egregious OON billing associated with COVID testing? New 4/14

Member balance billing is be monitored and addressed through UnitedHealthcare standard process, which includes member communication, and provider and member notifications around balance billing rules.

What, if anything is UnitedHealthcare doing from a health plan and/or policy perspective to protect employers from "unreasonable" costs related to COVID-19 testing/treatments given self-funded employers are paying 100% of costs for related in-network tests/treatments? New 4/14

UnitedHealthcare has implemented several processes to validate that claims paid for COVID tests strictly adhere to regulatory guidance and pricing. Claims can be reviewed both pre- and post-

payment, and any providers with aberrant billing practices will be subject to our Fraud, Waste and Abuse processes.

FSA, HRA, HSA ACCOUNTS

Were tax filing deadlines changed in 2021? New 4/7/2021

Yes, the 2020 tax filing & payment and HSA contribution deadlines have been extended.

The federal income tax filing deadline has been extended from April 15, 2021 to May 17, 2021 (IRS-2021-59). Taxpayers can also defer federal income tax payments from April 15, 2021 to May 17, 2021 without normal penalties and interest regardless of the amount owed. This deadline extension only applies to federal taxes; individuals should check their state's tax filing deadline as it may vary by state.

The amount of time that individuals have to make 2020 health savings account (HSA) contributions has also been extended to May 17 (IRS 2021-21). This notice also extends the due date for Form 5498-SA to June 30, 2021.

- The HSA contributions deadline extension will not impact any 2020 IRS 1099-SA forms necessary for filing taxes, which show 2020 HSA distributions.
- 2020 IRS form 5498-SA (which is informational only and not required for filing taxes) will be updated for any 2020 HSA contributions made through the May 17 contribution and filing deadline.
- If you have already filed your 2020 taxes or have additional questions regarding tax impact, please consult a tax professional.

We advise you to speak with your tax or benefits counsel regarding interpretation of the legislation.

How did the DOL Notice 2021-01 change timely filing requirements for HRA, HIA and FSA's? New 3/26/2021

The DOL notice extended timely filing for HRA, FSA and HIA to the earlier of; (i) 1 year from the end of the plan year plus their existing timely filing limit, or (ii) 60 days after the announced end of the National Emergency (the end of the Outbreak Period), plus any remaining time under their plan.

This does not apply to dependent care FSAs since a dependent care FSA is not an ERISA plan.

No action needed —Active HRA & HCFSA impacted plans to reflect a timely filing of 455 days (365 days plus 90-day timely filing).

What did the American Rescue Plan Act allow for Dependent Care FSA's? New 3/26/2021

Dependent Care FSA family maximum elections are temporarily changed to $10,500 (up from $5000) for the 2021 calendar year. This is an option and is not mandated. Customers should notify their UHC representative of their intent and UHC will process as a standard plan change.

Customers should always consult their legal team as they make any decisions related to plan changes, in particular those customers with non-calendar plan years should refer to their legal team to determine how this may impact their employees.

What temporary changes for FSA did the Appropriations Act, signed on 12/27/2020, allow customer to opt-in to? Update 2/2/2021

These temporary changes for both health and dependent care are optional for all employers. Employers may select to implement one or a combination of any they choose. None are mandates.

- **FSA Rollovers.** The Act allows health and dependent care FSA participants to carry over unused balances from a plan year ending in 2020 to a plan year ending in 2021 and from a plan year ending in 2021 to plan year ending in 2022.
- **FSA Grace Period Extension.** The Act allows a health and dependent care FSA grace period for a plan year ending in 2020 or 2021 to be extended 12 months after the end of such plan year.
- **Health FSA Reimbursements.** The Act permits a health FSA to allow an employee who ceases participation in the plan during 2020 or 2021 (for example, due to termination of employment) to continue to receive reimbursements from unused balances through the end of the plan year in which such participation ceased (including any grace period).
- **Dependent Care FSA Participation.** The Act permits dependent care FSA participants whose qualifying child turned age 13 during the pandemic to continue to receive reimbursements for such child's dependent care expenses for (1) the remainder of the plan year and, (2) to the extent a balance remains at the end of the plan year, the following plan year until the child turns age 14 (but only with respect to the unused amount). The plan year described in (1) must have had a regular enrollment period that was on or before January 31, 2020.
- **FSA Election Changes.** The Act permits health and dependent care FSA election changes for plan years ending in 2021, regardless of whether the employee has a permitted election change event. This extends the election change relief for FSAs provided in IRS Notice 2020-29 by one year.
- Amendments need to be adopted by the last day of the year after the plan year in which the amendment is effective. 2020 carryover amendments need to be made by December 31, 2021.

How will UHC administer the options available? New 1/14/2021

- Amounts that are unused in 2020 may be carried over to 2021 and amounts that are unused in 2021 may be carried over into 2022: UHC will allow all unused amounts remaining in the 2020 (or 2021) plan year for carryover, regardless of how it was applied. Unused amounts from any plan year prior to 2020 will not be included. Any other request will require internal review.
- Health and dependent care FSA grace periods for plan years ending in 2020 and/or 2021 may be extended until 12 months after the end of the plan year: UHC will extend the Grace Period for the customer.

- Plan participants who cease participation in the plan during 2020 and/or 2021 (terminated participants) may continue to be reimbursed if they have unused amounts in their health and/or dependent care FSA: Like dependent care FSA, termed members could incur claims after termination and spend remaining balances down.
- Plan participants will be permitted to make prospective changes to their health and/or dependent care FSAs during 2021 (without regard to change in status): We will manage those choices via our standard eligibility process.
- Reimbursement of expenses under a dependent care FSA for dependents who aged out during the COVID-19 pandemic. This will allow reimbursement for children who turned 13 on or after March 1, 2020 (which is the start of the pandemic) until the end of the pandemic.

If a customer were to implement the carryover rule for 2020 or 2020 & 2021, what are the implications when a participant moved to a qualified high deductible health plan (HSA plan)? 1/14/2021

If a customer allows the full carryover of unused 2020 funds (or 2021 funds) or elects the full 12-month Grace Period, then any member who may have moved to a qualified HDHP will be impacted. Both options allow members to incur claims and use their FSA funds. This is considered 1st dollar coverage under the HDHP. If a member already elected a limited FSA, we can move remaining balances to that limited FSA upon request. A decision will need to be made to communicate the impact to HSA members who did not already elect a limited FSA for 2021 or in 2022.

Will plan documents needs to be updated to allow for these changes? New 1/14/21

Yes. Amendments need to be adopted by the last day of the year after the plan year in which the amendment is effective. 2020 carryover amendments need to be made by December 31, 2021

How do I notify UnitedHealthcare which options we are electing? Update 2/2/2021

UnitedHealthcare is requesting that you notify your UHC Representative by February 15th, 2021.

UnitedHealthcare will manage the changes as a plan change. Therefore, all plan documents will need to be updated.

What did the final rule, which came out on May 4, 2020, require for FSA and HRA/HIA plans? Update 1/13/21

The DOL and IRS final rule extended timely filing for HRA and FSA until 60 days past the declared end of the Presidents federal Covid-19 Emergency period. The final rule calls this the Outbreak Period (Covid-19 President's declared emergency period plus 60 days).

This is a mandatory change for fully insured and self-funded ERISA plans that will allow members to continue to submit expenses incurred in 2019 or 2020 through the end of the Outbreak Period. This applies to HRA/HIA and health FSA's. This applies to all plans with runout in effect on or after March 1, 2020. If the end of the pandemic is declared **by the president**, the timely filing deadline will be 60 days from that date for any plan year impacted by the final rule. Reminder, this also includes plans ending 12/31/20 who renewed for 1/1/21.

This does not apply to dependent care FSAs since a dependent care FSA is not an ERISA plan.

No action needed —Active HRA & HCFSA impacted plans to be updated by 6/12/20.

Will the Joint Rule apply to only those customers with timely filing ending on or after 3/1/2020? New 5/24

Yes. The Final Rule prohibits plans from counting the time between March 1, 2020 (the date of the COVID-19 National Emergency announcement) and sixty (60) days following the end of the Emergency ("the Outbreak Period").

Examples:

- **Plan year ending 12/31/2019 and 90-day timely filing in place (ending 3/31/2020) — what is the expected action?** Extend timely filing.
- **Plan year ending 12/31/2019 and 30-day timely filing (ending Jan 30th, 2020) — what is the expected action?** Do not extend timely filing.
- **Plan year ending 11/30/2019 and 90-day timely filing in place (ending Feb 29) — what is the expected action?** Do not extend timely filing.
- **Plan year ending 10/30/2019 and 90-day timely filing in place (ending Jan 30) —what is the expected action?** Do not extend timely filing.
- **Plan year ending 6/30/2020 and 90-day timely filing (ending Sept 30th, 2020) — what is the expected outcome?** If emergency is not over, extend timely filing.

If a customer TERMED on 12/31/2019 or after and did not renew for 2020 what is the expected outcome for timely filing when UHC maintained runout period? Update 1/13/21

UnitedHealthcare will not extend timely filing for termed UnitedHealthcare cases. Final balance reports were provided after their existing timely filing ended, and customers should check with their current administrator on their approach to this mandate or contact their UnitedHealthcare representative with questions.

What types of financial accounts are covered under the Joint Statement? New 5/24

FSA, HRA and HIA (HRA incentive only funding). RRA's typically do not have a runout.

What recent notice changes were relaxed for employers with section 125 cafeteria plans? Update 6/16

In IRS Notice 2020-29 and 2020-33) the IRS allows employers to make temporary changes to section 125 cafeteria plans. These are choices an employer may opt-in to, it is not mandated. The temporary changes may extend the claims period for health FSAs and for dependent care FSA (DCAP) accounts to make mid-year changes.

- In IRS Notice 2020-29 and 2020-33) the IRS allows employers to make temporary changes to section 125 cafeteria plans. These are choices an employer may opt-in to, it is not mandated. The temporary changes may extend the claims period for health FSAs and for dependent care FSA (DCAP) accounts to make mid-year changes. Employers may limit decreases up to amounts already paid out.

- By opening this option, it will help members who wish to modify their early elections to address unanticipated changes in expenses due to COVID-19. This temporary relief may be applied retroactively to January 1, 2020.
- Customers should define their process to ensure decreases do not cause negative balances and send any election changes through the existing eligibility file process.
- Beginning with January 1, 2020, for plans with a health FSA carryover, the amount permitted has been increased to $550 for use in 2021.
- An option where the claim period for taxpayers to incur claims in 2020 and apply unused amounts remaining in a 2019 health FSA or dependent FSA has been extended to December 31, 2020.
- This will be processed as a standard plan change. Please be aware that if there are members who opened an HSA after their existing grace period was complete, extending it at this time has impacts to a member's eligibility to open an HSA. Grace period is also other 1st dollar coverage. A member is eligible to open an HSA the 1st of the month following the end of their grace period. Please consider this impact as you make your decision on this option.

Employers who choose to follow the recent guidance should modify their existing plan documents to accommodate these changes.

If a person has a flexible spending account to cover day care expenses this year but with the national emergency has had their children home and will not need as much in the dependent care account, can they adjust the amount they are contributing to the DCAP? New 6/2

The IRS guidance permits an employer to allow employees to increase or decrease contributions to their dependent care account based on whether they no longer need childcare or whether they now need childcare because they are working from home. The money in the dependent care account may be used for childcare or to pay for preschool, after school or summer camps. What's more if the person did not need a DCAP, but now does they can set one up now. Employers may limit decreases up to amounts already paid out.

This is not mandatory. It is the employer's decision if they wish to implement this change.

Will Dependent Care now allow for reimbursement of online or virtual camps? New 8/11

No. There has been no change to the definition of dependent care or related eligible expenses that would allow online or virtual camps to be reimbursed.

Can a person who did not use all their dollars in their 2019 FSA continue to use them throughout 2020? Update 6/16

Yes. Under the recent IRS guidance, an employer may extend the grace period allowing the person to continue using any unused 2019 FSA contributions without losing the money.

An employer may also choose to allow their employees to increase, decrease or rescind their 2020 election. The employee is not allowed to cash out their FSA account. Whatever money is already in their FSA they would have to use through the end of 2020 or their grace period in 2021. If they have a

carryover provision with their FSA, they can carryover up to $550 of the money in their 2020 FSA into their 2021 FSA account.

- This will be processed as a standard plan change.
- Please be aware that if there are members who opened an HSA after their existing grace period was complete, extending it at this time has impacts to a member's eligibility to open an HSA.
- Grace period is also other 1st dollar coverage. A member is eligible to open an HSA the 1st of the month following the end of their grace period. Please consider this impact as you make your decision on this option.

Does the increase amount for FSA carryover mean I could move some money from my 2020 FSA to my 2019 FSA to pay for more 2019 expenses? New 5/20

No. The additional $50 applies to the contribution to the 2020 health FSA carryover for use in 2021. It does not apply retroactively.

What options do employees have for their UnitedHealthcare FSA? Update 5/28

Based on current regulations and subject to any restrictions or limitations that may exist specific to individual plan documents and design, employees may have existing options to modify their pre-tax elections for a Dependent Care FSA (DCFSA) to support their needs at this time. Employees may be able to change their elections back to their current election if circumstances change again, such as the daycare center reopening or the employee going back to work in the office). Several examples include:

- Decrease or suspend election:
  - If the daycare has closed and is not billing for services. They may choose to re-elect the DCFSA once daycare services resume.
  - Due to quarantine or illness, the employee is unable to use the daycare.
  - The daycare provider has adjusted its fee schedule during this time.
  - An employee and/or his/her spouse is working from home and needs the daycare services for less hours per day.
- Modify, increase or add election:
  - The daycare provider has adjusted its fee schedule during this time.
  - A child is switched from a paid provider to "free care" (i.e. neighbor or relative) or no care.
  - An employee and/or his/her spouse is working from home and needs the daycare services for less hours per day.
  - An employee and his/her spouse are working from home and needs to hire a babysitter to care for children while they are working in their home. This will qualify so long as the babysitter is over the age of 19 and is **not** the spouse, the parent of the child, or anyone claimed as a dependent on the employee's tax returns.

Customers should consult with their own legal counsel and review their plan language.

Can UnitedHealthcare extend timely filing deadlines for FSA? Update 6/16

A customer may change that today. All plan documents would need to be updated. Recent guidance does expand this for the Outbreak Period as noted below. Effective March 1, 2020 and through the end of a yet-to-be determined "Outbreak Period" (generally 60 days after the end of the COVID-19 national emergency), any deadlines for filing health care FSA claims and appeals are suspended

This is a mandatory change for fully insured and self-funded ERISA plans that will allow members to continue to submit expenses incurred in 2019 through the end of the Outbreak Period. This applies to HRA/HIA and health FSA's. This applies to runout in effect on or after March 1, 2020.

This does not apply to dependent care FSAs since a dependent care FSA is not an ERISA plan.

No action needed — Active HRA & HCFSA impacted plans to be updated by 6/12/20.

Will Grace Period (to pay claims incurred this year for an extra 2.5 months from prior year balances) get extended due the current situation? Update 6/16

Yes. An option exists where the claim period for taxpayers to incur claims and apply unused amounts remaining in a 2019 health FSA or dependent FSA has been extended to December 31, 2020.

Employers who choose to follow the recent guidance should modify their existing plan documents to accommodate these changes.

- This will be processed as a standard plan change. Please be aware that if there are members who opened an HSA after their existing grace period was complete, extending it at this time has impacts to a member's eligibility to open an HSA.
- Grace period is also other 1st dollar coverage. A member is eligible to open an HSA the 1st of the month following the end of their grace period. Please consider this impact as you make your decision on this option.

Will the IRS allow any unused DCFSA balances to the carryover, so members do not lose them? Update 6/16

Under current rules, a DCFSA may include a 2.5-month grace period following the end of the plan year in which participants may continue to incur expenses that are reimbursable from the account balance, if any, remaining at the end of the plan year.

IRS Notice 2020-29 allows employers, but does not mandate, to make temporary changes to section 125 cafeteria plans.

The claim period for taxpayers to apply unused amounts remaining in a 2019 health FSA or dependent FSA has been extended to December 31, 2020.

- This will be processed as a standard plan change. Please be aware that if there are members who opened an HSA after their existing grace period was complete, extending it at this time has impacts to a member's eligibility to open an HSA.
- Grace period is also other 1st dollar coverage. A member is eligible to open an HSA the 1st of the month following the end of their grace period. Please consider this impact as you make your decision on this option.

If a customer elected carryover originally, does the notice allow them to change to grace period during 2020? Update 6/16

Yes, if the customer's plan year is not a calendar year plan and it ends during 2020, they can change to grace period. Groups with calendar plans that began Jan. 1,2020, may not retroactively switch from carryover to a grace period.

- An option exists where the claim period for taxpayers to incur claims and apply unused amounts remaining in a 2019 health FSA or dependent FSA has been extended to December 31, 2020.
- Employers who choose to follow the recent guidance should modify their existing plan documents to accommodate these changes.
- Customers may choose either carryover or grace period on the next renewal.

Can a member with a DCFSA account submit claims even if they have stopped contributing to the account? New 4/13

The customer may allow employees to change their elections and to spend down their DCFSA.

As long as the customer doesn't term that member, then the member may submit a claim for any applicable date of service in order to be reimbursed from the remaining DCFSA balance.

Where can people get information on their UnitedHealthcare FSA or other account-based plans – FSA, HRA, and HSA? New 4/1

People may visit myuhc.com or optumbank.com for the latest developments and up-to-date information on regulation changes related to health care spending and savings accounts.

We are prepared to partner with you as changes occur to ensure you have necessary information and know what steps to take.

Can members who have to stay home with children stop contributions to a Dependent Child (DC) FSA? New 4/1

The current IRS regulations allow a participant to discontinue contributions to their DCAPs when they are not actively at work or on an approved leave of absence. The employee may be considered not eligible to participate since the daycare is not needed for the employee to maintain gainful employment. This may also be viewed as a change in status allowing the employee to request a change in their current election.

Therefore, the employee may be permitted to discontinue their election to contribute or change their election to stop contributing. Once the employee need daycare services, they could re-enroll in the DCAP and begin contributing again. The customer's plan language should address this.

Customers should consult with their own legal counsel and review their plan language.

If an employee is furloughed but not terminated can a customer continue to keep them on 'active' FSA coverage to spend down balances? Update 5/29

If the employee is not terminated the leave of absence provisions that would otherwise apply under the plan would determine the employee's options during furlough. For example, the plan may apply rules similar to those that are required under FMLA and allow the employee to continue coverage if he/she makes payments during the leave or makes catch up payments following the leave. It is up to the employer how they want to handle. The employer may need to amend its plan language.

Did the CARES Act change the requirement for prescriptions for over the counter (OTC) medications? Update 5/29

Yes. The CARES ACT (COVID Stimulus Bill) that was recently passed by Congress permanently reinstates coverage of over the counter (OTC) drugs and medicines as eligible for reimbursement from FSAs, HRAs, HSAs, and Archer MSAs without need for a prescription.

It further expands the definition of qualified reimbursable items to include menstrual care products. This will apply automatically to any account type that currently covers OTC. UnitedHealthcare will not change eligible expenses to those accounts not currently covering OTC, such as an HRA that only pays expenses that a medical plan would cover.

This change is effective for expenses incurred on or after January 1, 2020.

Healthcare Spending Card may be used to pay for OTC without a prescription.

What happens of the spending card does not work on the OTC purchases? Update 5/20

A member may use the accounts to purchase the products. Members should first try to use the card as they normally would to make the purchase. If the sale does not process, the person may pay out of pocket and then reimburse themselves with their account funds. Keep the itemized receipts, which are needed to verify the purchases so they can be reimbursed.

To search for qualified medical expenses, go to FSAstore.com.

Reminder for HSAs, the debit card may be used as it normally is since no claim reimbursement process is required. As always, the receipts should be kept for tax purposes.

Since the tax deadline was moved to July 15, 2020, can individuals continue to contribute to 2019 HSA? Update 5/29

Yes, the federal income tax payment and filing deadlines have been extended from April 15, 2020 to July 15, 2020 (Refer to IRS announcement IR-2020-58, Notice 2020-17 and Notice 2020-18).

In addition, the IRS issued FAQs on Notice 2020-18. Notice 2020-18: https://www.irs.gov/newsroom/filing-and-payment-deadlines-questions-and-answers. Q&A 21 states, "Contributions may be made to your HSA or Archer MSA, for a particular year, at any time during the year or by the due date for filing your return for that year. Because the due date for filing Federal income tax returns is now July 15, 2020, under this relief, you may make contributions to your HSA or Archer MSA for 2019 at any time up to July 15, 2020."

individuals may continue to make 2019 health savings account (HSA) contributions to July 15, 2020.

Can High-deductible health plans (HDHPs) with an HSA provide pre-deducible coverage for telehealth or Virtual Visits? Update 5/29

The Coronavirus Aid, Relief, and Economic Security (CARES) Act allows HSA qualified high deductible health plans to cover telehealth services **for any condition** before the deductible is met. Change is effective for plan years on or before 12/31/2021. This relief should also apply to Virtual Visits.

Therefore, pursuant to this law, High Deductible Health Plans (HDHPs) may provide pre-deductible coverage for telehealth and other remote care services without impacting an individual's ability to contribute to his/her HSA. This provision will last until December 31, 2021. The plan year must begin prior to this date.

Can a member close or make an adjustment to their Commuter Expense Reimbursement Adjustment Account (CERA)? New 4/1

Yes. Individuals may adjust or discontinue their payment to the account. Go to myuhc.com and under Plan Balance select Manage CERA. Funds in the account may be used for future commuter expenses within plan guidelines.

ALL SAVERS

Note: The public health emergency was extended through January 15, 2022.

INFORMATION IN THIS SECTION IS SPECIFIC TO ALL SAVERS.

Is there a Virtual Visit option for members?

Virtual Visit options are available to members in many plans. Where available, and if covered under the member's plan, members can schedule a Virtual Visit with a provider. Virtual Visit providers **Teladoc®, HealthiestYou, AmWell®** and **Doctor On Demand™** have developed guidelines for members who think they may have been infected by COVID-19.

A member's Virtual Visit is a good place to discuss concerns and symptoms. Where indicated, the Virtual Visit provider may refer the member to their physician.

When a COVID-19 diagnostic test is done, the test and test-related virtual visit will be covered at no cost share when billed with the appropriate codes.

How does this change apply to All Savers? Update 6/8

All Savers level-funded members already have access to $0 Virtual Visits through our partnership with HealthiestYou. For the All Savers fully insured membership that does not currently have access to this benefit, this service will be available to them until September 30, 2020.

Has UnitedHealthcare changed Telehealth guidelines for All Savers? Update 10/24

To increase system access and flexibility when it is needed most, we are expanding our telehealth policies to make it easier for people to connect with their health care provider. People will have access to telehealth services in two ways – through a Virtual Visit national provider or through a medical provider, such as the members physician.

- **COVID-19 Telehealth:** Cost share waiver (copayment, deductible, coinsurance) for in-network and out-of-network telehealth coverage for COVID-19-related services.
- **Non COVID in-network telehealth services:** Through September 30, 2020, cost share is waived for in-network non-COVID covered telehealth services, for individual and fully insured group market health plans, and for self-funded employers that opted in.
- **Non COVID out-of-network telehealth services:** Out-of-network telehealth services do not include the cost-share waiver and is processed in accordance with the group's health benefits plan if the service is eligible. Expanded telehealth non-COVID-19 services ended July 24, 2020.

- **Virtual Visits**: For individual and group market health plan members, many members can access their Virtual Visits benefits through one of UnitedHealthcare's national designated providers (HealthiestYou) without any cost share (copayment, deductible or coinsurance) through the public health emergency. COVID-19 diagnosis will be reimbursed based on zero cost share. After September 30, the member pays copay upfront and be reimbursed for COVID diagnostic service. Non-COVID-19 Virtual Visits end September 30, 2020.

- **Expanded Provider telehealth Access for COVID-19** — Effective March 18, and through December 31, 2020, all eligible network medical providers who have the ability and want to connect with their patient through synchronous virtual care (live video conferencing) or audio-only (telephone) can do so. Effective dates may vary based on state laws. This applies to all fully insured clients and self- insured clients that are following the fully insured guidelines.

Do we send All Savers subscribers to UHC.com also? Are all the same practices being done by both UHC and All Savers? Update 11/19

For general information on COVID-19, All Savers members can utilize UHC.com; benefit specific information is on the All Savers member portal myallsaversconnect.com. All Savers is following the same practices that are in place as with Fully Insured. including coverage during reduction of work hours, and Virtual Visit and telehealth coverage.

Will All Savers consider relaxing current eligibility rules requiring employees to work 30 or more hours per week to be eligible for benefits so employees whose hours are reduced, or employees are furloughed due to reduced work from COVID-19 situation can still be covered? Update 7/31

For health plan products: UnitedHealthcare is temporarily relaxing its requirement that employees be actively working to be eligible for coverage and will allow you to cover your reduced hour employees, who were eligible for and enrolled in coverage prior to the reduction in hours, if you pay the monthly premium. Please note that you must offer this coverage on a uniform, non-discriminatory basis.

If the employee is on a customer-approved leave of absence/furlough and the customer continues to pay required medical premiums, the coverage will remain in force the later of the public health emergency, or:

- No longer than 20 consecutive weeks for non-medical leaves (i.e., temporarily laid off).
- No longer than 26 consecutive weeks for a medical leave.

Note coverage may be extended, if required by local, state or federal rules.

Will Risk Management allow a grace period for employers to respond, post group termination, due to the COVID-19 national emergency? Update 5/25

For groups who have renewal dates in May and June, we allowed 60- or 30-day extensions, respectively. Note that no further extensions for groups renewing in July or later will occur. July and later renewal date groups are required to respond to renewal audits as stated in the audit notification letter.

Will renewal rate actions be delayed as a result of the COVID-19 National Emergency? New 3/30

Renewals and all necessary information will be released on a timely basis.

If my group's enrollment drops by more than 10% as a result of the COVID-19 National Emergency, will my rates and premiums on my All Savers plan be subject to change? NEW 4/8

Small group rates and premiums will not be adjusted at the time of new group coverage or off renewal.

For large group, for the present time, if the loss of enrollment is a result of the COVID-19 situation, rates and premiums will not be adjusted at the time of new group coverage or off renewal.

Will UnitedHealthcare waive any rehire waiting period for employees terminated due to COVID-19 whom I hire back? Update 11/23

Yes. As the employer, you have the option to waive the waiting period and follow existing eligibility rules with respect to date of event or first of month.

Will United waive the waiting period for insured customers' newly hired employees? New 4/22

No.

What continuation of coverage applies to my All Savers plan and one or more employees are terminated as a result of COVID-19? New 3/30

Standard COBRA continuation protocols apply.

If I terminate employees in the middle of the month as a result of COVID-19, will my All Savers coverage extend for the terminated employees until the end of the month? New 3/30

If premiums have been remitted for the month, coverage will continue through the end of that month.

What if employees are terminated and either they do not elect COBRA or there is no COBRA available because the group health plan has been discontinued or group is not eligible for COBRA? New 3/30

If employees are terminated and either they do not elect COBRA or there is no COBRA available, the employee has the opportunity to enroll in the Exchange in their state. Both Small employers and Individuals must elect Exchange Market Place Coverage within 60 days of the termination, or they will have to wait until the next open enrollment period.

UnitedHealthcare offers people a range of individual health insurance plans. Interested individuals may contact (800) 827-9990 to speak with an advisor who can assist.

They can also visit https://www.healthmarkets.com to apply directly.

Are telehealth visits covered for behavioral health as well as medical for All Savers? Update 6/88

All Savers members will have access to behavioral health services through our Virtual Visit partnership with HealthiestYou. Members will have the ability to schedule a behavioral health appointment in the HealthiestYou mobile app.

All Savers® fully insured product

Administrative services may be provided by United HealthCare Services, Inc. and its affiliates for insurance products underwritten by All Savers Insurance Company. 3100 AMS Blvd., Green Bay, WI 54313, (800) 291-2634.

All Savers® Alternate Funding
Administrative services provided by United HealthCare Services, Inc. or their affiliates. Stop-loss insurance is underwritten by All Savers Insurance Company (except MA, MN, and NJ), UnitedHealthcare Insurance Company in MA and MN, and UnitedHealthcare Life Insurance Company in NJ. 3100 AMS Blvd., Green Bay, WI 54313 (800) 291-2634.

What has been extended for COVID-19 treatment? New 12/29

Between Jan. 1, 2021 and Jan. 31, 2021, UnitedHealthcare has extended medically necessary network inpatient COVID-19 treatment at no cost share for fully insured groups and for All Savers and ASO groups that follow UnitedHealthcare standard COVID-19 coverage.

This extension applies only to inpatient COVID-19 treatment with a COVID-19 diagnosis.

Does this treatment extension apply to All Savers? Update 12/29

Yes, we are extending the policy to our All Savers plans. All Savers groups will have medically necessary inpatient COVID-19 treatment at no cost share extended through January 31/2021. For All Savers clients who have questions, they should call the All Savers Customer Call Center at (800) 291-2634.

COVID-19 VACCINES

Where will COVID-19 vaccines be available? New 12/22

Initially, COVID-19 vaccines will be available at certain locations. The state health department is a resource for learning about local availability.

As vaccines become more widely available, people will be able to get the COVID-19 vaccination at participating retail pharmacies, such as CVS and Walgreens, as well as doctor's offices, hospitals and federally qualified health centers.

What documentation will be required to get the vaccine? Update 12/22

- For All Savers plans, show the All Savers medical ID card.
- At the vaccination appointment, health care professionals will likely want to understand the member's health status. Members should be prepared to share current medical conditions and medications. The member's All Savers online account is also a resource where members can find a snapshot of their health status, including medical conditions and medications.

As more is known, this information will be updated.

When should people get the second dose of the COVID-19 vaccine? New 12/22

The first COVID-19 vaccine from Pfizer-BioNTech will require 2 doses, given 3 weeks apart. We encourage members to schedule appointments for both doses. You will need to get the second dose in 3 weeks following the first dose to get protection from COVID-19.

Will UnitedHealthcare cover the COVID-19 vaccine, and how will they cover the vaccine? Update 10/17/21

Yes. Members will have $0 cost-share (copayment, coinsurance or deductible) for FDA-authorized COVID-19 vaccines, as outlined below, including when two doses are required:

- For All Savers plans, members have $0 cost-share at both in- and out-of-network providers through the national public health emergency period, currently scheduled to end January 15, 2022. This applies to Alternate Funded Plans and Fully Insured.

What is the process for approving FDA-authorized vaccines and then how do members know if they are eligible for a COVID-19 vaccine and where can they get a vaccine? Update 12/12

As a COVID-19 vaccines are FDA authorized for emergency use, the Advisory Committee of Immunization Practices (ACIP) meets to recommend it, and if recommended the Centers for Disease Control and Prevention (CDC) Director will review and approve who should get the vaccine first.

It is likely the vaccine will first be made available to health care workers and residents of long-term care facilities, then essential workers and people at high risk, such as those over 65 years old or with certain medical conditions.
At first, we expect the vaccine to be at limited health care sites because of storage needs and availability. We will keep uhc.com updated as more information on locations becomes available.

Members who are selected to be in the first groups to get a COVID-19 vaccine can go their state health department to find vaccine providers. Members can also speak to their primary care provider or other health care professional to better understand what they should do given their specific health conditions.

How are COVID-19 vaccines covered? Update 12/22

The COVID-19 vaccine serum will initially be paid by the government.

For All Savers plans, UnitedHealthcare and Alternate Funded customers will cover the administration of COVID-19 vaccines with no cost share for in-and out-of-network providers, during the national public health emergency period. Administration fees for in-network providers will be based on contracted rates. Administration fees for out-of-network providers will be based on CMS published rates.

What is the member and plan sponsor cost share? New 12/22

The COVID-19 vaccine serum will initially be paid by the government. Eligible members receiving the vaccine will not have any out-of-pocket costs.

For All Savers Plans, UnitedHealthcare and Alternate Funded customers will be required to cover the administration of COVID-19 vaccines with no cost share for in- and out-of-network providers, during the national public health emergency period. Administration fees for in-network providers will be based on contracted rates. Administration fees for out-of-network providers will be based on CMS published rates.

Where can I go for more information? Update 12/22

8 things to know about COVID-19 vaccines from the CDC

Authorized COVID-19 vaccines from the FDA

COVID-19 vaccine myths debunked

CDC COVID-19 Vaccines

FDA COVID-19 Vaccines

UnitedHealthcare COVID-19 Member Resource Center

Provider Resources

- CMS Enrollment for Administering COVID-19 Vaccine Shots
- CMS Medicare Billing for COVID-19 Vaccine Shot Administration
- CMS Coding for COVID-19 Vaccine Shots
- CMS COVID-19 Vaccine Shot Payment
- Roster Billing Guidance
- UnitedHealthcare COVID-19 Billing Guide
  COVID-19 Vaccine Member Center