OLC No. 0803 0083

VIRGIN ISLANDS DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

September 11, 2023

VIA SHAREPOINT©
Honorable Albert Bryan Jr.
Governor of the Virgin Islands
Government House
Nos. 21-22 Kongens Gade
St. Thomas, VI 00802

Attn: Richard T. Evangelista, Esq.
Chief Legal Counsel to the Governor

Re: Agreement for Medical Health Insurance between the Government of the Virgin Islands, through the GESC/Health Insurance Board of Trustees, and UnitedHealthcare Insurance Company

A.G. File No. K-23-0372

Dear Governor Bryan:

Transmitted herewith for your approval is the Agreement for Medical Health Insurance ("MAPD Agreement") by and between the Government of the Virgin Islands, through the GESC/Health Insurance Board of Trustees ("Board")("Government"), the University of the Virgin Islands ("UVI"), the Virgin Islands Housing Authority (the "Authority"), hereinafter collectively referred to as the ("Employer" or "Group") and UnitedHealthcare Insurance Company (hereinafter "United").

The Term of the MAPD Agreement is twelve (12) months, beginning January 1, 2024, and ending December 31, 2024, and subject to your approval. The MAPD Agreement is subject to annual review and renewal, with terms to be renegotiated by the parties, for up to four (4) successive twelve (12) month terms if the Government gives United notice of its intent to renew the Agreement at least sixty (60) days before the expiration of the term of the contract. The premium amounts are detailed in Addendum I to the Agreement and further detailed below. The Government will remit premium payments under Addenda 1, 2, and 3 terms.

According to the Justification Letter from the Board, dated August 29, 2023, the Board acting as the sole body overseeing the operation of the Government employees' health and other benefit plans, has recently secured bids with UnitedHealthcare after completing a Request for Proposals (RFP) for competitive bids as required by statute for insurance services last year which included Medical and Prescription Drug coverage for active employees and retirees, Employee Assistance Program, Dental, Vision, Life and Accidental Death & Dismemberment (AD&D) plans.

UnitedHealthcare was the only insurer that responded to the post-65 retiree coverage and maintained a competitive advantage in the Territory being licensed to offer a group Medicare Advantage plan. UnitedHealthcare began its partnership with the Government in 2013, offering its AARP Medicare Supplement plans alongside a custom Medicare Part D Prescription Drug Plan (PDP). The plans offered significant savings to the Government and retirees. Over the years, we have worked with UnitedHealthcare to ensure a long-term and sustainable program for the Government and retirees.

The Justification Letter also states that in 2017, the Board recommended offering the stateside retirees two Medicare Advantage Plans with Prescription Drug Coverage (MAPD), which further reduced costs to the Government and eased administrative burdens while maximizing benefits for stateside retirees. That plan proved extremely successful, with a smooth transition and a retiree satisfaction score of 95%.

For 2021, UnitedHealthcare received approval for the Territorial retirees to participate in the group Medicare Advantage plan offered by UnitedHealthcare, which covers everything covered by original Medicare with additional benefits, including health and wellness, routine vision checks, hearing checks, podiatry, chiropractic, and prescription drugs.

All post-65 retirees are covered by one plan regardless of whether they are Territorial or Stateside residents. Coverage is nationwide; retirees are not required to select a Primary Care Physician (PCP), and referrals are not required to see a Specialist. The proposed rate for the existing plan offered today is a 20% increase above current premiums or an increase of $3.8 million for the 2024 calendar year. Those rates reflect changes and updates from the 2024 Final Call Notice on March 31, 2023. The Final Call Notice had significant changes to growth rates, Part C Risk Adjustment Model Changes, and Part C Risk Adjustment Coding, negatively impacting the funding insurance companies receive from CMS for 2024.

The Justification Letter further states that the Board, through its consultant, Gehring Group, negotiated an option to eliminate a fiscal impact on the Government and retirees. To achieve no increase in premiums, the Board recommended adding a $500 deductible, the same amount as the pre-65 retiree plan. Also, there will be a $250 per inpatient hospital admission copayment and a $100 emergency room copayment. Protecting the retirees is a $1,000 annual out-of-pocket maximum. Making these changes will save $588 per post-65 retiree per year. Importantly, the deductible does not apply to Primary Care Office Visits, Telemedicine Visits, Emergency Room

Visits, Urgent Care Visits, Diabetic Monitoring Supplies, Hospice, Preventive Visits, Vision, and Hearing Visits.

Premiums are submitted for regulatory approval to CMS and the Office of the Lieutenant Governor Division of Banking, Insurance, and Financial Regulation, and the monthly premium has been approved effective January 1, 2024, through December 31, 2024, at no increase. The monthly premium will be $250.24 per person per month. Based on current cost-share, the Government's portion of the premium would be $12,908,120, and the retirees' portion would be $6,649,638.

Additional program enhancements included for 2024 at no additional cost to continuously care for Virgin Island retirees are as follows:

- UnitedHealthcare Hearing Aide Enhancements
    - Retirees can utilize their hearing aid allowance to purchase non-prescription (over-the-counter) hearing aids through UHC Hearing. Retirees can save thousands of dollars, making hearing aids more accessible and affordable.
- Continuous Glucose Monitors (CGMs)
    - CGMs provide users with real-time information about their blood glucose levels around the clock, leading to better diabetes management and improved health outcomes. The coverage criteria for CGMs have been expanded to more retirees with diabetes who are not just dependent on insulin and now also include those with certain hypoglycemia conditions.
- Let's Move
    - A wellness program coordinated and designed to integrate self-service, virtual, and in-person wellness programming focused on nutrition, physical activity, mental health, social well-being, and financial wellness, amongst other benefits.
- Marriage and Family Therapy.
    - Retirees can see Medicare-eligible mental health counselors (MHCs) and marriage and family therapists (MFTs).

In addition, Medicare Retirees will continue to receive a quarterly Grocery Store Benefit. Retirees will receive a $40 credit each quarter to spend locally on healthy food and over-the-counter products. Credits are added to a debit card on the first day of each quarter (in January, April, July, and October) and expire at the end of the year. House Calls will also continue for 2024. Also, UnitedHealthcare will continue offering $200,000 to their Wellness Incentive Fund, allowing the GESC and the Government to provide wellness incentives and initiatives for Medicare Retirees.

I have attached for your review the following documents:

1. Certificate of Authority (no business license is required because insurance companies are not engaged in any business, occupation, profession, or trade listed in 27 V.I.C. § 302);
2. Certificate of Authority for Sierra Health and Life Insurance Company, Inc.
3. Div. of Bank. Ins. and Finan. Reg. Letter to Sierra Health re Certificate of Authority dated January 10, 2023;
4. Authorization for Signatory by Assistant Secretary's Certificate;
5. Delegation of Authority Policy;
6. GESC/Health Insurance Board of Trustees letter dated August 29, 2023;
7. Group Health projected budget;
8. United Healthcare Group Medicare Advantage (PPO) Chart and Benefits Explanation;
9. Articles of Incorporation for United and Sierra; and
10. MAPD Agreement.

Thank you for considering this matter. The MAPD Agreement and supporting documents have been reviewed and approved for legal sufficiency. If you have questions, please contact Assistant Attorney General Ian S.A. Clement Esq. or me at 340-774-5666.

Sincerely,

Pamela R. Tepper
Solicitor General

Enclosures: MAPD Agreement and Supporting Documents

cc: Ariel M. Smith, Esq., Attorney General
Department of Justice

Beverly Joseph, Chairperson
GESC Health Insurance Board

Valerie P. Daley, Chief Health Insurance
Division of Personnel

AGREEMENT FOR MEDICAL HEALTH INSURANCE

THIS AGREEMENT FOR MEDICAL HEALTH INSURANCE (this "Agreement") is made and entered into this 1st day of January 2024 by and between the Government of the Virgin Islands, through the GESC Health Insurance Board of Trustees, (the "Government"), the University of the Virgin Islands ("UVI"), the Virgin Islands Housing Authority (the "Authority"), (the Government, UVI and the Authority hereinafter collectively referred to as (the "Employer" or "Group") and UnitedHealthcare Insurance Company ("United") and its affiliates.

WITNESSETH:

WHEREAS, United is a Medicare prescription drug plan sponsor certified by the Centers for Medicare & Medicaid Services to offer Medicare Advantage with prescription drug benefits plan; and

WHEREAS, United is a Medicare prescription drug plan sponsor certified by the Centers for Medicare & Medicaid Services to offer Medicare Advantage with prescription drug benefits plan; and

WHEREAS, United also provides commercial wrap prescription drug plan coverage also known as a RxSupplement plan that supplements its Medicare Advantage with prescription drug benefits plan. The commercial wrap prescription drug plan is a fully-insured state filed insurance product; and

WHEREAS, Employer desires to provide Medicare Advantage with prescription drug benefits plan with RxSupplement ("MA-PD Plan") for its eligible retirees and their dependents; and

WHEREAS, the Employer consists of the Government of the Virgin Islands and its independent instrumentalities; and

WHEREAS, the terms of this Agreement shall consist of the terms provided herein and the terms of the addenda and attached exhibits which are fully incorporated herein by reference; and **NOW THEREFORE**, for and in consideration of the mutual covenants and promises made herein, the parties agree as follows:

1. TERM

This Contract shall be in force and effect for a term of twelve (12) months beginning January 1, 2024, and ending December 31, 2024. This contract is subject to annual review and renewal, with terms to be renegotiated by the parties, for up to four (4) successive twelve (12) month terms. The Employer shall give notice of its intent to renew the contract at least sixty (60) days prior to the expiration of the term of the contract.

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2. PREMIUMS

A. Premium amounts are provided for in Addendum 1. Employer shall remit premium payments to United in accordance with the terms contained in Addenda 1, 2 and 3 to this Agreement.

B. Future premiums shall be calculated in accordance with United's standard underwriting policies and procedures then the effect.

3. BENEFITS PLAN

The MA-PD Plan benefits provided to Employer's eligible retirees and their eligible dependents by United are as described in Addendum 4 to this Agreement.

4. EVIDENCE OF COVERAGE

The Evidence of Coverage ("EOC") will be supplied by United and issued to Members of the MA-PD Plan in accordance with Medicare Laws and Regulations. The EOC discloses and sets forth the plan benefits and terms and conditions of coverage to which Members of the MA-PD Plan are entitled.

5. REPORTS

United shall provide Employer with the following reports free of charge:

MA-PD Plan Reporting

A. Executive Summary (quarterly)

In addition to standard reports (currently listed in the contract), any non-standard ad hoc reports shall be produced on terms mutually agreed upon by United and Employer.

6. ELIGIBILITY AND ENROLLMENT

United shall accept and provide coverage for all Employer's eligible retirees and their eligible dependents.

7. PERFORMANCE GUARANTEES

A. United and Employer have agreed upon certain performance guarantees as set forth in Addendum 2. Failure to satisfy any of the performance guarantees shall not, by itself, constitute a material breach of this Agreement.

B. The performance guarantees set forth below are effective as of January 1, 2024 (the "Commencement Date"). The term of the performance guarantees shall be from the

Commencement Date through December 31, 2024, and thereafter annually renew each January 1 (the "Term").

C. The total amount payable by United during the Term for failure to meet the performance commitments shall be in accordance with Addendum 2.

D. Change in Reporting Format or Measurement. United reserves the right to replace or modify any performance commitment if necessitated by a change in circumstances that would cause the performance commitment to be an inaccurate or unfair method of measuring United's performance. In such event, the performance commitment will be modified to the degree necessary to carry out the intent of the parties.

E. Setoff. Employer shall be entitled to set-off any amount owed by United to Employer under this Agreement against any debt owed by Employer to United, whether now existing or hereafter arising. Notwithstanding the foregoing, this subsection E shall only apply to any amounts owed under the PDP Plan.

F. Force Majeure

Notwithstanding any other Force Majeure clauses in this Agreement, with the exception of the obligations set forth in Addendum 3, United shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of United, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by United, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

G. Termination of Performance Guarantees

The provisions of this Section 7 and Addendum 2 to this Agreement with respect to Performance Guarantees shall terminate upon the earliest of the following dates:

1. the end of the Term;

2. the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

3. the date upon which the Employer fails to pay any premium charges, fees or other charges within the time frame specified in Addendum 1;

4. the date upon which the Agreement under which United provides services to the Employer is terminated;

5. any other date mutually agreeable to the Employer and United.

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8. LOCAL CUSTOMER REPRESENTATIVES

United agrees to provide two local service representatives who will be on-site in the Districts of St. Thomas and St. Croix. The office will be open for business five (5) days per week with hours no less than from 8:00 a.m. to 5:00 p.m., with exceptions for holidays, vacations, and training. United will work with the Employer to determine day-to-day customer service for post 65 retirees as well as retirees aging into Employer's retirement program. Customer service will include, but is not limited to assisting post 65 retirees with all member related issues for the benefits offered as well as any wellness related activities as mutually developed by United and Employer. United will continually monitor and assess the workload of both on-site representatives to ensure customer service levels are appropriately staffed.

9. WELLNESS STRATEGIES

United will fund a Wellness Strategy, for wellness programs as outlined below. Funding for these initiatives shall not derive from Medicare Federal dollars. United will fund wellness programs that are mutually agreed upon between United and Employer to support wellness initiatives. United will reimburse Employer for the cost of these wellness programs within a reasonable time after United receives an appropriate invoice from Employer. The cost to United for these wellness programs provided during any one calendar year will not exceed $200,000. Such wellness initiatives, as stated in United's RFP response for the AARP Medicare Supplement Plan for post-65 retirees, will include Nurse Healthline, MyHealthReflections, and additional health and wellness online resources. United's cost to provide existing available programs such as Nurse Healthline, MyHealthReflections, and additional health and wellness online resources will not apply to the $200,000 annual cost budget.

10. APPROVAL and CONTRACT EFFECTIVE DATE

This Agreement is subject to and shall become effective upon the approval of the Governor of the Virgin Islands and the Legislature of the Virgin Islands.

11. TAXES and LICENSURE

United shall maintain the appropriate licenses to conduct business in the Virgin Islands and shall pay all applicable fees and taxes imposed by the Federal and Territorial government agencies, for its operations in the Virgin Islands. United shall also comply with all applicable local and federal laws and rules and regulations pertaining to insurance and insurance transactions the Virgin Islands.

12. LIABILITY OF OTHERS

Nothing in this Agreement shall be construed to impose any liability upon the Employer by persons, firms, associations, or corporations engaged by United as servants, agents, independent contractors, or in any other capacity whatsoever, or make the Employer liable to any such persons, firms, associations or corporations for the acts, omissions, responsibilities, obligations and taxes

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of United of whatsoever nature, including but not limited to unemployment insurance and social security taxes for United, its servants, agents or independent contractors.

13. ASSIGNMENT

(a) Assignment. United shall not assign any rights under this Agreement without the prior written approval of Employer, which approval shall not be unreasonably withheld.

(b) Delegation. Nothing set forth herein, however, shall preclude United from assigning or subcontracting to its subsidiaries, affiliates or any successor in interest any of its obligations due and owing to Employer. Moreover, nothing herein shall preclude United from assigning or subcontracting any obligations to any entity currently performing services for United. Any such subcontracting or assignment shall not relieve United of the ultimate responsibility for the performance of the Agreement.

(c) Employer shall not assign any part of the services under this contract to any instrumentalities or agencies not specifically named in this document without the prior written approval of United, which approval shall not be unreasonably withheld.

14. INDEMNIFICATION

United agrees to indemnify, defend and hold harmless the Employer from and against any and all loss, damage, liability, claims, demands, detriments, cost charges and expenses (including attorney's fees) and causes of action of whatsoever character which the Employer may incur, sustain or be subjected to, arising out of or in any way connected to the services to be performed by United, its affiliates, subcontractors or agents under this contract and arising from any cause, except the sole negligence of the Employer.

United's duty to indemnify, defend and hold Employer harmless shall not extend to acts or omissions of participating or non-participating providers who provide services in any network for Employer's retirees and their eligible dependents enrolled in United's MA-PD Plan hereunder.

Employer agrees to indemnify, defend and hold United, and its affiliates, harmless, and to accept all legal and financial responsibility for any liability (including reasonable attorneys' fees) arising out of its own failure to perform its obligations as set forth in this Agreement, under Medicare Laws and Regulations, or other applicable state or federal laws.

15. United AND AARP Names, Logos and Service Marks

United reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. Employer shall not use United's or AARP's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of United.

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16. INDEPENDENT CONTRACTOR

United shall perform this Agreement as an independent contractor and nothing herein contained shall be construed to be inconsistent with this relationship or status.

17. TERMINATION

A. This Agreement may be terminated only as follows:

1. By mutual agreement of the parties.

2. By either party, if it deems that it is in its best interest to do so. The terminating party shall give the other party SIXTY (60) CALENDAR DAYS written notice of its intent to terminate this Agreement. In the event of termination under this paragraph, Employer shall be liable for premium payments up to and including the date of termination.

3. By Employer, in the event of a material breach of this Agreement by United. For purposes of the paragraph, a material breach is a violation or nonperformance of an Agreement term that is substantial and significant, may result in a liability to Employer, or may give rise to a cause of action against United by Employer. Employer shall give United written notice of its intention to terminate ("Notice of Intent") this Agreement pursuant to this paragraph, which Notice of Intent shall specify the duties and responsibilities that United has failed to perform. Thereupon, United shall have a period of THIRTY (30) CALENDAR DAYS following receipt of said Notice of Intent to cure such failure or failures. If United cures such failure or failures in conformance with the requirements of this Agreement and within said 30-day period, the Notice of Intent shall be deemed rescinded. If, however, United fails to cure such failure or failures within said 30-day period, this Agreement shall terminate upon the lapse of the 30-day period, unless the parties shall otherwise agree in writing. Notwithstanding the foregoing, this Section 17(A)(3) does not apply to the performance guarantees as provided herein and in Addendum 4.

4. By United, in the event of a material breach of this Agreement by Employer. For purposes of the paragraph, a material breach is a violation or nonperformance of an Agreement term that is substantial and significant or that may give rise to a cause of action against the Employer by United. United shall give the Employer written notice of its intention to terminate this Agreement pursuant to this paragraph ("Notice of Intent"), which Notice of Intent shall specify the duties and responsibilities that Employer has failed to perform or the reasons that lead United to the conclusion to terminate. Thereupon, Employer shall have a period of THIRTY (30) CALENDAR DAYS following receipt of said Notice of Intent to cure such failure or failures. If Employer cures such failure or failures in conformance with the requirements of the Agreement and within said 30-day period, the Notice of

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Intent shall be deemed rescinded. If, however, Employer fails to cure such failure or failures within said 30-day period, this Agreement shall terminate upon the lapse of the 30-day period, unless the parties shall otherwise agree in writing. In the event of termination under this paragraph, the United shall be entitled to premium payments up to and including the date of termination.

5. Pursuant to additional termination provisions in Addendum 4 as it relates to the MA-PD Plan.

B. Notice of termination shall be given a party by certified mail with return receipt requested, addressed to the other party as provided in Section 28 of this Agreement, and shall specify with particularity the nature and date of the termination.

C. In the event of termination, Employer has the sole responsibility to fulfill requirements (if any) of notifying eligible retirees and their eligible dependents of any state or federal conversion or continuation of coverage rights or benefits to which eligible retirees and their eligible dependents might he entitled. United has no responsibilities, liabilities, or duties related to this notification.

D. Notwithstanding anything herein to the contrary, in the event this Agreement is terminated, United shall continue to provide the MA-PD Plan benefits as required by Medicare Laws and Regulations, as defined in Addenda 4 ("Medicare Laws and Regulations") or applicable law.

18. GOVERNING LAW

A. This Agreement shall be governed by the laws of the United States Virgin Islands to the extent not superseded or preempted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, 42 U.S.C. § 1395 et seq. and jurisdiction over any matter or dispute with respect to this Agreement in a court of competent jurisdiction sitting in the U.S. Virgin Islands.

B. United covenants that it has familiarized itself with the applicable provisions of Title 22, Virgin Islands Code.

19. WAIVERS AND AMENDMENTS

No waiver, modification or amendment of any term, condition or provision of this Agreement shall be valid or of any force or effect unless made in writing, signed by the parties hereto or their duly authorized representative, and specifying with particularity the nature and extent of such waiver, modification or amendment. Any such waiver, modification or amendment in any instance or instances shall in no event be construed to be a general waiver, modification or amendment of any of the terms, conditions or provisions of this Agreement, but the same shall be

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strictly limited and restricted to the extent and occasion specified in such signed writing or writings.

20. AUTHORITY

Each party warrants and represents that it is authorized to enter into this Agreement, and agrees to be bound by the terms herein. The parties further warrant and represent that the persons signing on their behalf are representatives of the entity with proper and sufficient authority to bind the entity to the terms of this Agreement.

21. RETENTION OF RECORDS AND ACCESS BY GOVERNMENT AGENCIES

United shall maintain all records books, accounting records and other information pertaining to the services under this Agreement as required by applicable Federal or State law and make such materials available at their respective offices at all reasonable times, for inspection by authorized officials of the United States Virgin Islands, and concerned Federal agencies who are legally authorized to review such records. The documentation described in this Section 21 shall be retained and preserved in accordance with applicable Federal or State law.

Each party agrees that any information furnished it under this Agreement shall be used only for the authorized functions to be performed under this Agreement, and may not be further disclosed without the written permission of the other party. Any disclosure of the existence of this Agreement or the terms of this Agreement with United may only be made with the prior written consent of United, except as otherwise required by law.

22. UNITED PERSONNEL

United shall commit a cohesive, designated, highly trained skilled core team to the management and administration of the MA-PD Plan (said team hereinafter referred to as the "Government Plan Management Team"). United shall also assign an account representative, who shall be a member of said core team, and who shall be available as needed to respond to inquiries from the Government. United shall provide Employer with the names of the individual constituting the Government Plan Management Team and a brief summary of the qualifications and professional experience of such individual. United shall advise the Government of any change in the composition of the Government Plan Management Team.

23. CONDITION PRECEDENT

This Agreement shall be subject to the availability and appropriation of funds and to the approval of the Governor. In addition, this Agreement is subject to the approval of the Legislature of the United States Virgin Islands ("Legislature").

24. NON-DISCRIMINATION

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No person shall be excluded from participating in, be denied the proceeds of; or be subject to discrimination in the performance of this Agreement on account of race, creed, color, sex, religion, national origin or disability.

25. CONFLICT OF INTEREST

United covenants that it is:

(A) Not a territorial officer or employee (i.e., the Governor, Lieutenant Governor, member of the Legislature or any other elected territorial official; or an officer or employee of the legislative, executive or judicial branch of the Government or any agency, board, commission or independent instrumentality of the Government. whether compensation on a salary. fee or contractual basis); or

(B) a territorial officer or employee and, as such, has:

(1) familiarized itself with the provisions of Title 3, Chapter 37, Virgin Islands Code, pertaining to conflicts of interest, including the penalties provision set forth in section 1108 thereof;

(2) not made, negotiated or influenced this contract, in its official capacity;

(3) no financial interest in the contract as that term is defined in section 1101, (1) of said Code chapter.

26. CONTINGENT FEE PROHIBITED

United warrants that it has not employed or retained any individual, corporation, partnership or other entity, other than a bona fide employee or agent working for United to solicit or secure this Agreement, and that it has not paid or agreed to pay any individual, corporation, partnership or other entity, other than a bona fide employee or agent any fee or other consideration contingent on the making of this Agreement.

27. ENTIRE AGREEMENT

The terms and provisions of the addenda and exhibits, if any, attached to this Agreement are incorporated into and made a part of this Agreement. This Agreement constitutes the entire agreement between the parties hereto, and all prior understandings or communications, written or oral, with respect to the subject matter of this Agreement, are merged and integrated herein. With respect to the Evidence of Coverage described in Addendum 4 and incorporated herein by reference, any item not explicitly discussed in this document which is discussed in said exhibit shall be controlled by the terms of said exhibit.

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28. NOTICES

Any notice required to be given by the terms of this Agreement shall be deemed to have been given when the same is sent by certified mail, postage prepaid or personally delivered, addressed to the parties as follows:

Employer:
Chief. Group Insurance program
Virgin Islands Division of Personnel
34 — 38 Kronprindsens Gade
GERS Complex, 3rd Floor
St. Thomas, Virgin Islands 00802

United:
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-3408
Attention: President

29. DEBARMENT CERTIFICATION

By execution of this contract, United certifies that it is eligible to receive contract awards using federally appropriated funds and that it has not been suspended or debarred from entering into contracts with any federal agency. If, during the term of this contract, United shall become ineligible to receive contract awards using federal funds, this contract may be terminated for cause forthwith or at such future date as Employer may specify and United shall not be entitled to payment for any coverage performed under this contract or sub-contract after the effective date of such termination.

30. FALSE CLAIMS

United warrants that it shall not, with respect to this Agreement, make or present any claim upon or against Employer, knowing such claim to be false, fictitious or fraudulent. United acknowledges that making such a false, fictitious, or fraudulent claim is an offense under Virgin Islands law.

31. CONFIDENTIAL INFORMATION

Confidential Information means without limitation the following, regardless of form or the manner in which it is furnished: (a) pricing, discounts, reimbursement terms, payment methodologies and payment processes, compensation arrangements and any similar commercial information ("Rate Information") and (b) data, information, statistics, trade secrets and any information about business, costs, operations, techniques, know-how or intellectual property. Any material that is derived from or developed from Confidential Information will be deemed Confidential Information for purposes of this Agreement, regardless of the person creating,

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disclosing or making available such material. Any Confidential Information included in preparations, proposals, scope documents, discussions, findings, summaries, reports and conclusions remains Confidential Information. .

Each party will limit the use of the other's Confidential Information to only the information required to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. Neither party will disclose the other's Confidential Information to any person or entity other than to the receiving party's employees, subcontractors, or authorized agents needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. Notwithstanding the foregoing, United's Rate Information cannot be disclosed to any third party without United's express written consent and, if required by United, a mutually agreed upon confidentiality agreement. Employer may not sell, license, or grant any other rights to Confidential Information.

If Employer needs access to United's Confidential Information, United, at its discretion, may allow Employer to use United's Confidential Information subject to the following conditions:

(1) The information requested must relate to United's services under this Agreement;

(2) Employer must give United reasonable advance notice and an explanation of the need for United's Confidential Information;

(3) It must be legally permissible for United to release such information;

(4) The release and use must be consistent with United's provider contractual obligations; and

(5) The release and use must be consistent with United's data use and release policies.

Such use is subject to the terms of this Agreement and as required by United, a mutually agreed upon confidentiality agreement.

If Employer is subject to a Freedom of Information Act (FOIA) request and the request includes United's Confidential Information, Employer will contact United prior to releasing any information and give United the opportunity to review, respond, and/or object to the FOIA request.

United also will provide reasonable access to information to an entity providing Plan administrative services to Employer, such as a consultant or vendor, if Employer requests it. Such access is subject to the conditions in this Section. Before United provides Confidential Information to that entity, the parties must sign a mutually agreed-upon confidentiality agreement, and the parties must agree as to what information is minimally necessary to accomplish the Plan administrative service.

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United will provide information only while this Agreement is in effect and for a period of six (6) months after the Agreement terminates, unless Employer demonstrates that the information is in response to a subpoena, legal process, or other release of information required by applicable law.

Employer is responsible for entering into any and all legally required agreements with consultant or vendor to ensure protection of Protected Health Information, including but not limited to, a Business Associate Agreement, as defined under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended from time to time.

This provision shall survive the termination of this Agreement.

32. PROTECTED HEALTH INFORMATION CERTIFICATION

In executing this Agreement, Employer certifies that as plan sponsor it has in place appropriate plan documents necessary to demonstrate compliance with applicable privacy requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA"). Employer further certifies that its plan documents meet the following requirements: (a) plan documents describe employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information to be disclosed, provided that any employee or person who receives protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description; (b) restrict the access to and use by such employees and other persons described in the above to the plan administration functions that the plan sponsor performs for the group health plan; (c) provide an effective mechanism for resolving any issues of noncompliance by persons described above with the plan document provisions required by law; and (d) the plan documents comply with the requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from United to perform the plan administration functions.

Specifically, the plan sponsor will:

a. Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

b. Ensure that any agents, including a subcontractor, to whom it provides protected health information received from United, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

c. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

d. Report to United any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

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e. Make available protected health information in accordance with 45 CFR §164.524;

f. Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526;

g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

h. Make its internal practices, books and records relating to the use and disclosure of protected health information received from United available in response to an inquiry from United or an appropriate regulatory entity for purposes of determining compliance with federal privacy requirements;

i. If feasible, return or destroy all protected health information received from the United that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

33. SEVERABILITY

If any term or condition of this Agreement or the application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application.

34. HEADINGS NOT CONTROLLING

Section headings in this Agreement are for convenience only and shall have no binding force or effect and shall not enter into the interpretation of the Agreement.

35. NO THIRD-PARTY BENEFICIARIES

Except as otherwise expressly indicated in this Agreement, this Agreement shall not create any rights in any third parties who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

36. COUNTERPARTS AND FACSIMILE

This Agreement may be executed in counterparts, each of which shall constitute an original and all or which, when taken together, shall constitute one and the same instrument. The parties agree that documents, including this Agreement, may be transmitted electronically and by facsimile and that executed electronic and facsimile documents, including this Agreement, shall be deemed an original and shall be binding on the party executing said document.

37. SURVIVAL

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The following sections of this Agreement shall survive termination of the Agreement: 14 and 21.

Signature page follows.

IN WITNESS WHEREOF the parties through their authorized representative set their signatures on the day and year indicated.

GESC Health Insurance Board of Trustees

By: _____
Name: Beverly Joseph
Title: Chairperson
Date: August 30, 2023

UnitedHealthcare Insurance Company

By: _____
Name: Michael Grossman
Title: COO, URS
Date: August 28, 2023

University of the Virgin Islands

By: _____
Name: David Hall
Title: President
Date: 9/5/2023

Virgin Islands Housing Authority

By: _____
Name: Robert Graham
Title:

Date: _____

Approved for Legal sufficiency

Department of Justice

By: /s/ _____ Date: September 7, 2023
Assistant Attorney General

IN WITNESS WHEREOF the parties through their authorized representative set their signatures on the day and year indicated.

GESC Health Insurance Board of Trustees

By: _____
Name: _____
Title: Chairperson
Date: _____

UnitedHealthcare Insurance Company

By: _____
Name: Michael Grossman
Title: COO, URS
Date: August 28, 2023

University of the Virgin Islands

By: _____
Name: David Hall
Title: _____
Date: _____

Virgin Islands Housing Authority

By: _____
Name: Robert Graham
Title: Executive Director
Date: 9/5/2023

Approved for Legal sufficiency

Department of Justice

By: _____ Date: _____, 2023
Assistant Attorney General

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UnitedHealthcare Insurance Company
Medical Health Insurance Contract for Plan Year 2024

Approved:

_____ Date: 9/14, 2023
Honorable Albert Bryan Jr.
Governor of the Virgin Islands

Approved:

_____ Date: _____, 2023
Novelle E. Francis, Jr.
President, 35th Legislature of the Virgin Islands

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ADDENDUM 1

2019 PDP Plan, MA-PD Plan and Medicare Supplement Plan

Premium Rates

The rates set forth in this Addendum 1 include the MA-PD Plan and administrative charges for services agreed to be made available to the Employer under these plans.

MA-PD Plan

The MA-PD Plan premium rate for the 2024 calendar year is **$250.24** per person per month .

Stipulations

- This is a Final quote effective 1/1/2024 - 12/31/2024. The situs state is Virgin Islands.
- This quote assumes that the employer pays 65% of the premium.
- If members who have previously opted out are to be allowed back into the plan, then this fact must be disclosed at the time of quote.
- If the enrollment were to change by more than +/- 10% from current enrollment, we reserve the right to adjust the rates.
- Please note the following with regard to the drug coverage on these MAPD products: (i) We reserve the right to change our Part D formulary for calendar year 2024 . We also reserve the right to change our pharmacy benefit manager and/or our pharmacy network for calendar year 2024. (ii) There is a specific, Part D drug formulary that applies to all of our MAPD plan offerings. (iii) Part D prescription drug coverage is considered to be creditable, therefore Creditable Coverage Notices are not required.
- United reserves the right to modify its 2024 rates in the event of changes to existing laws, regulations, or any new legislation, assessments, taxes, and/or marketplace changes to the Medicare Advantage and Part D programs that will have an impact to the program costs or revenue, including but not limited to: (i) any changes to the Part D program including, but not limited to, any current proposals or legislation that have not yet been finalized (Please note that this proposal does account for the portions of the Inflation Reduction Act that are effective 1/1/2023 and 1/1/2024 but does not account for any impacts due to the portions of the Inflation Reduction Act that are scheduled to become effective 1/1/2025 and forward); (ii) changes in the methodology used to calculate CMS payments including any changes due to EGWP bid waiver; (iii) any plan design changes required by the applicable regulatory authority (i.e. mandated benefits); (iv) any Force Majeure event, including but not limited to national pandemic, act of God, acts of terrorism, or anything beyond United's reasonable control; or (v) as otherwise permitted in our contract This quote assumes that the Point-of Sale (POS) Rebate Rule will not be effective as of January 1, 2024. If the POS Rebate Rule becomes effective as of January 1, 2024, United will modify the 2024 rates accordingly.
- Quote assumes $0.00 PMPM commission level.
- 71 Pre-65 Medicare eligible retirees are included.
- The premium rate quoted herein assumes that premiums are due in full on a monthly basis on or before the last business day of the month.

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ADDENDUM 2

Performance Guarantees

The following performance guarantees are effective January 1, 2024.

PROPRIETARY AND CONFIDENTIAL
GVI
Performance Guarantees

The below performance guarantees (these "Performance Guarantees") are effective for the term of this Agreement provided, however, United may specify to Group new Performance Guarantees upon a subsequent anniversary of the Effective Date . Any new Performance Guarantees must be in writing between the parties and shall supersede and replace these Performance Guarantees. With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Group's exclusive financial remedies.

These Performance Guarantees will become effective upon the later of (1) the Effective Date of this Agreement; or (2) the date this Agreement is signed by both parties. In the event these Performance Guarantees become effective later than the Effective Date of this Agreement: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the next anniversary of the Effective Date following the date this Agreement is signed by both parties.

These Performance Guarantees can be modified to the degree necessary to carry out the intent of the parties. United shall not be required to meet any of these Performance Guarantees or amendments thereto to the extent United's failure to meet these Performance Guarantees is due to fire, embargo, strike, war, accident, act of God, acts of terrorism; or United's required compliance with any law, regulation, or governmental agency mandate; or anything beyond United's reasonable control.

Total Fees at Risk for all Medicare Advantage Medical Performance Guarantees		2% of total employer paid premium annually
Product		PPO plan
Member Phone Service		
Phone service guarantees and standards apply to Member calls made to the customer care center that primarily services Group members.		
Abandonment Rate		
Definition	The percentage of calls queued that abandon (hang up) will be no greater than the percentage set forth.	
Measurement	The percentage of calls queued that abandon (hang up) before being answered by a representative.	3%
§ Criteria	Standard system tracking reports.	
§ Level	Group Retiree Medicare Advantage book of business.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Service Level		

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Definition	The percentage of answered member calls that are answered within the parameters set forth.	
Measurement	Percentage of calls answered.	80%
	Time answered in seconds, on average.	seconds
§ Criteria	Standard system tracking reports.	
§ Level	Group Retiree Medicare Advantage book of business.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Operations		
Dollar Accuracy		
Definition	Claims dollars paid accurately will not be less than the designated percent.	
Measurement	Percentage of claims dollars paid accurately.	99%
§ Criteria	Standard Claims Operations Report.	
	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim processed without payment errors. Measurement: (Sample Claim Dollars Paid - Mispaid) / Sample Claim Dollars Paid.	
§ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Procedural Accuracy		
Definition	Procedural accuracy rate of not less than the designated percent.	
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors.	97%
§ Criteria	Standard Claims Operations Report.	
	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim processed without payment errors.	
§ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Payment Accuracy		
Definition	Claims Payment Accuracy Percentage will not be less than the designated percent.	
Measurement	Percentage of sampled claims paid without errors.	97%
§ Criteria	Standard Claims Operations Report.	

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	(Number of Sampled Claims - Number of Sampled Claims with Financial Defects) / Number of Sampled Claims.	
§ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Time to Process in 30 calendar days		
Definition	The percentage of all claims United receives will be processed within the designated number of calendar days of receipt.	
Measurement	Percentage of clean claims processed (Par and Non Par Providers, including paid and un paid claims).	95%
	Calendar days after receipt.	30
§ Criteria	Standard Claims Operations Report.	
§ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Eligibility File		
Eligibility File Load		
Definition	Member Applications processed within the designated number of calendar days of receipt of properly completed applications.	
Measurement	Percentage of member applications or enrollment files processed within seven (7) calendar days of receipt (must be received by ***12:00 noon EST*** otherwise they are considered received on the following calendar day)	95%
§ Criteria	Standard system tracking reports; the guarantee is waived for member applications that cannot be processed because they have been not properly completed.	
§ Level	Customer specific.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Fulfillment - ID Cards		
New Member ID Card Distribution		
Definition	New Member ID Cards will be postmarked within the parameters set forth.	

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Measurement	Percentage of new member ID cards mailed within seven (7) calendar days of receiving CMS approval.	99%
§ Criteria	Calculated on the actual number of new member ID cards mailed within seven (7) calendar days divided by the total number of member applications.	
§ Level	Customer specific.	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claim Operations - Pharmacy		
Electronic Claim Turnaround Time		
Definition	The number of seconds taken to process all clean electronic pharmacy claims received.	
Measurement	Percentage of claims processed : As measured by the total elapsed time from the point a transaction is received by United's pharmacy system from the dispensing pharmacy until the submitted transaction is adjudicated and appropriate claim payment information is issued.	99%
§ Criteria	Time to process, not to exceed.	3 seconds
§ Level	Book of Business (UHCMR).	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Retail Paper Claims Paid in 14 Days (PROMPT PAY DMR CLAIMS)		
Definition	The percentage of all clean pharmacy claims United receives will be processed within the designated number of calendar days of receipt.	
Measurement	Percentage of clean pharmacy claims processed.	99%
§ Criteria	Time to process, in calendar days or less after receipt of clean claim.	14
§ Level	Book of Business (UHCMR).	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Retail and Mail Order Clean Claim Processing Accuracy		
Definition	Accuracy rate of not less than the designated percent.	
Measurement	Percentage of paper and electronic clean pharmacy drug claims processed accurately and with no errors.	99%
§ Criteria	Statistically significant random sample of clean pharmacy claims processed is reviewed to determine the percentage of claims processed without errors.	
§ Level	Book of Business (UHCMR).	

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§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Home Delivery Prescription Dispensing Timeliness - Intervention (Pharmacy)		
Definition	Average dispensing time, for all mail order prescriptions that require administrative or clinical intervention, no greater than as set forth.	
Measurement		100%
	Average dispensing time in business days.	5
§ Criteria	Average dispensing time is derived by dividing the total whole days to dispense all prescriptions by the total number of prescriptions dispensed, based on the date a prescription order is received and the date the order is shipped. Orders where the prescriber or Participants fails to respond will be excluded.	
§ Level	Book of Business (UHCMR).	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Home Delivery Prescription Dispensing Timeliness - Clean (Pharmacy)		
Definition	Average dispensing time for all mail order prescriptions that require no administrative or clinical intervention, no greater than as set forth.	
Measurement		100%
	Average dispensing time in business days.	2
§ Criteria	Average dispensing time is derived by dividing the total whole days to dispense all prescriptions by the total number of prescriptions dispensed, based on the date a prescription order is received and the date the order is shipped.	
§ Level	Book of Business (UHCMR).	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Home Delivery Prescription Dispensing Accuracy (Pharmacy)		
Definition	Mail order dispensing accuracy rating of the guaranteed percentage.	
Measurement	Percentage of prescriptions dispensed accurately.	99.99%
§ Criteria	External feedback will be collected and tracked from individuals receiving prescriptions for home delivery.	

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	This guarantee is conditional upon utilization of United's standard pharmacy management claim processing protocols.	
§ Level	Book of Business (UHCMR).	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Processing System Availability (Pharmacy)		
Definition	United guarantees that the pharmacy point of service system will be available a minimum of the displayed percentage of the time, not including scheduled downtime for maintenance, system updates, and telecommunication failures.	
Measurement	Percentage of time the system is available.	99.80%
§ Criteria	United's internal systems measures.	
§ Level	Book of Business (UHCMR).	
§ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Service Account Management Issue Resolution: Years 1 & 2		
Definition	Inventory of issues resolved in 2 business days	
Measurement	Percentage of issues received by the Service Account Management team that are resolved in 2 business days.	Year 1 - 85% Year 2 - 90%
§ Criteria	Measured as the percentage of issues that are received by the UHC Service Account Management team that are resolved in 2 business days divided by the total number of issues received by that team	
§ Level	Book of Business	
§ Period	Reported Quarterly	
Payment Period	Annually (aggregated results)	
Fees at Risk	Dollars at risk for this metric	Total at risk divided equally between all measures

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ADDENDUM 3

FORCES MAJEURE OR MAJESTURE

The parties agree that Forces Majeure or Majesture such as acts of God or nature, fires, floods, storms, or earthquakes may prevent one or both parties from performing its obligations under the Agreement. Therefore, the parties agree that the following provisions shall apply.

Article I Notice

In the event Forces Majeure or Majesture may prevent performance of one party's obligations, that party shall notify the other party in writing as soon as reasonably possible.

Article II In the Event United Cannot Perform

In the event United, or its subcontractors, cannot perform its obligations due to Forces Majeure or Majesture. United shall make all reasonable efforts to resume performance of such obligations. Such efforts shall include, but not be limited to, the following:

a. Location of a facility by which claims payment operations would continue within 2 business days of a force majeure event

b. Resumption of customer service operations within 2 business days of such event. Operations established pursuant to this section should be in place to handle not only ongoing claims issues, but historic claims and customer service issues that may arise due to ongoing service. The following PDP Plan and MA-PD Plan services shall be included in such operations:

Pre-authorizations

Medical Case Management

Coordinated transfer of cases to the US Mainland

Network management

Payment of claims

In addition, United is responsible to retain, historic record of claims data in a manner that would protect its integrity in the event of such a force majeure event.

United shall have safeguards to protect incoming data —paper or otherwise — in a manner by which no more than one day's claims receipts would be lost.

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Article III In the Event the Employer Cannot Perform

a. Non-financial obligations

In the event the Employer cannot reasonably perform its "non-financial" obligations due to Forces Majeure or Majesture, the Employer shall make all reasonable efforts to resume performance of such obligations. For the purposes of this Addendum, "non-financial" means obligations other than payment of premium.

b. Financial Obligations

In the event the Employer cannot reasonably perform its financial obligations within the time periods allotted in the Agreement due to Forces Majeure or Majesture events, the Employer shall immediately notify United and shall immediately request a "90 Day Premium Delay." Such notice shall be mailed within 30 days of the occurrence of the Forces Majeure or Majesture.

Article IV 90 Day Premium Delay

Upon receiving a valid request to invoke the 90 Day Premium Delay, United shall suspend any efforts to collect premium from the Employer. The 90 Day Premium Delay shall be considered effective on the day after the last date for which premium was paid.

Example 1: The Employer's premium is fully paid through August 31. On September15, the Employer makes a valid request for a 90 Day Premium Delay. The Premium Delay is deemed to be effective on September 1, the day after the last day for which premium was paid. The Premium Delay shall extend for 90 days to December 1.

The 90 Day Premium Delay does not relieve the Employer from the obligation to pay for the coverage in effect during the 90 Day Premium Delay.

a. United Obligations

United shall not invoice the Employer for 90 days from the last due date prior to the 90 Day Premium Delay taking effect. United shall continue to perform its obligations under the Agreement as required. When United resumes invoicing the Employer, such invoices shall be done in accordance with the terms of the Agreement, except that such invoices shall be for 100% of the premium owed:

(i) to the period during which the 90 Day Premium Delay was in effect, and during which premiums were not received;

(ii) then to any period after the 90 Day Premium Delay for which premiums were not collected;

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(iii) finally to any current or future period for which premiums are due.

Example 2: The Employer requests a premium delay that takes effect on September1. United does not invoice the Employer for premiums during September, October, or November. United invoices the Employer for premiums in December, which the Employer pays. The premium received is applied by United to the amount due for the month of September. Premiums received in January will be applied to October, and so on.

Application of new premium payments toward delayed premium payments shall not extend beyond the annual term of the Agreement. Except however, moneys paid by the employer in excess of the premiums due in the new contract year will be applied by United to reduce outstanding amounts, including periods for which moneys are owed due to the invocation of a 90 Day Premium Delay.

Example 3: The Employer has invoked a 90 day premium delay and made subsequent payments described in Example 1. On March 31, the Agreement Year ends. The Employer pays the monthly premium for April. This amount is NOT applied to the outstanding balance from the previous year. In May, the Employer pays an amount equal to one and a half times the monthly premium invoiced. The amount in excess of the May premium shall be applied by United to the amount outstanding due to the 90 day premium delay.

Any premiums not collected during the annual term of the Agreement shall remain due to United.

b. Agreement Provisions Applicable

Delayed premiums shall be subject to all provisions of the Agreement regarding invoicing, payment, and late charges, if any. Delayed premiums shall be considered late payments and subject to any interest and fees provided for in the Agreement or the addenda.

c. Advanced Payment

Nothing in this provision shall be construed to limit or prevent the Employer from reimbursing United all or some of the moneys owed due to the 90 Day Premium Delay earlier than might be required. Such advanced payments shall diminish any interest charges, late fees, or other penalties, as is appropriate under the terms of the Agreement and the addenda and exhibits thereto.

d. Not to Be Construed as Compromise or Settlement

The application of funds under this Article is in no way to be construed as constituting a compromise and settlement of the full amounts owed under the Agreement.

e. 90 Day Premium Delay Inapplicable

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In the event that the Employer properly requests, and United invokes, the 90 Day Premium Delay in accordance with this section, such 90 Day Premium Delay will be revoked if the Employer is determined to be paying other debts and obligations (not due and owing to United) on a timely basis. Upon revocation of such 90 Day Premium Delay pursuant to this subsection f, all premiums due and owing will be due immediately due and payable, and failure to make such payments will result in termination of the underlying Agreements and policy, subject to the notice requirements set forth therein.

Article V. Continuing Responsibilities

Any delay in performance granted to either party due to Forces Majeure or Majesture do not release either party from the responsibility for fulfilling the delayed obligations required by the Agreement and its addenda, except as may be permitted by the Agreement or its addenda. Failure to perform these obligations may result in either party invoking the termination provisions of the Agreement, as may be appropriate.

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ADDENDUM 4

MEDICARE ADVANTAGE WITH PRESCRIPTION DRUG BENEFIT PLAN

This Addendum 4 to this Agreement provides additional provisions specific to the Medicare Advantage with prescription drug benefit plan with RxSupplement plan (hereinafter referred to as "MA-PD Plan" or "Plan"). This Addendum 4 applies only to the Plan.

SECTION 1 - DEFINITIONS

Addendum is this Medicare Advantage with Prescription Drug Benefit Plan with RxSupplement Plan addendum, including, but not limited to any attachments or exhibits to this Addendum and any amendments thereto, and by reference, the Evidence of Coverage and Summary of Benefits, RxSupplement Plan Certificate of Coverage, and any amendments thereto.

Bonus Drugs are prescription drugs and drug products that are covered by the Plan through the RxSupplement Plan coverage.

Centers for Medicare & Medicaid Services ("CMS") is a Federal agency within the United States Department of Health and Human Services and is responsible for administering various Medicare programs.

Coinsurance is the portion of medical expenses for a service the Member must pay out-of-pocket, usually a fixed percentage. Coinsurance is usually applied after a deductible or Copayment requirement is met. Coinsurance is in addition to the Plan Beneficiary Premium.

Copayment(s) is a fixed dollar amount payable to a health care provider or pharmacy by the Member when the Member receives a health care service or product that is covered by the Plan. Copayments are in addition to the Plan Beneficiary Premium.

Covered Services are the health care services and products covered pursuant to the current terms of the Plan. Covered Services include Medicare Part D eligible prescription drugs and drug products covered pursuant to the current terms of the Plan, in compliance with Medicare Laws and Regulations.

Eligible Dependent(s) is any person defined as a qualified dependent by Group, who meets all the eligibility requirements of Group and the Plan, and who is eligible to enroll in a plan under the Medicare Laws and Regulations and who permanently resides within the Service Area.

Eligible Retiree(s) is a former Group employee who has met the minimum required retiree participation conditions as determined by Group, who is eligible to enroll in a plan under the Medicare Laws and Regulations, who meets the eligibility and enrollment requirements of the Plan, and who permanently resides in the Service Area.

Enrollment is the enrollment of Group's Eligible Retirees and Eligible Dependents into the Plan by Group. Enrollment is conditioned upon acceptance of the Eligible Retiree or Eligible

Dependent by United and by CMS, the execution of this Agreement by United and by Group, and the receipt of Plan Beneficiary Premium by United.

Evidence of Coverage ("EOC") is the document supplied by United and issued to Members disclosing and setting forth the health care benefits and terms and conditions of coverage of the Plan to which Members are entitled. The EOC is incorporated fully into this Addendum by reference.

Group is the entity(ies) identified in this Agreement.

Group Contribution is the amount of the Plan Beneficiary Premium applicable to each Member which is paid by Group.

Low Income Subsidy ("LIS") is a low-income subsidy provided to a LIS-eligible Member for the cost of the Member's premium or drug cost-sharing coverage under a Plan that provides Part D prescription drug benefit coverage, as described in Medicare Laws and Regulations.

Plan is the Medicare Advantage with prescription drug benefit plan described in this Addendum and the RxSupplement Plan, subject to modification, amendment or termination pursuant to the terms of this Addendum and the Plan.

Plan Beneficiary Premium is an amount established by United to be paid to United by or on behalf of each Member enrolled in the Plan for coverage under the Plan. If the Plan provides coverage for prescription drugs, the Plan Beneficiary Premium may include late enrollment penalties as assessed by CMS for those Members who did not have creditable prescription drug coverage for a period that exceeds sixty-three (63) calendar days from or after eligibility for Medicare Part D Plan. Plan Beneficiary Premium will not include Income Related Monthly Adjustment Amounts (IRMAA), if any, as assessed and billed to Member by the Social Security Administration to certain individuals with higher incomes. Member is responsible for the payment of IRMAA and if not paid, Member will be disenrolled from the Plan by CMS.

Medicare Laws and Regulations are, collectively, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"), the Medicare Improvements for Patients and Providers Act of 2008, the Patient Protection and Affordable Care Act, the regulations implementing the Medicare Advantage provisions at 42 CFR Part 422, together with guidance, instruction and other directives from CMS relating to Medicare Advantage Plans, and as applicable the regulations implementing the Medicare Part D Plan provisions of the MMA at 42 CFR Part 423, together with guidance, instruction and other directives from CMS relating to the Medicare Part D Plan.

Medicare Part D Plan is a Medicare Part D prescription drug benefit plan.

Member is the Eligible Retiree and/or Eligible Dependent who is eligible and covered by the Plan.

Open Enrollment Period is the annual period established by Group, or if no Open Enrollment Period is declared by Group, another period required by CMS, during which all eligible and prospective Group Eligible Retirees and Eligible Dependents may enroll in the Plan.

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RxSupplement Plan Certificate of Coverage ("RxSupplement COC") is the document supplied by United and issued to Members disclosing and setting forth the prescription drug benefits, terms and conditions and coverage of the RxSupplement Plan portion of the Plan.

Service Area is a geographic area approved by CMS within which a Plan Member must permanently reside in order to enroll in the Plan.

SECTION 2 - ELIGIBILITY AND ENROLLMENT

2.01 Eligibility.

The Plan specifies the coverage for which Eligible Retirees and Eligible Dependents are eligible, in consideration of their continued entitlement to Medicare Part A and enrollment in Part B, and in consideration of United's receipt of any specified Plan Beneficiary Premium. Only persons with Medicare Parts A and B are allowed to be enrolled in the Plan. The Member is responsible for paying the appropriate premiums for Medicare Part A and/or Part B.

2.02 Submission of Eligibility List and Enrollment Election Forms.

Group shall submit Eligible Retirees and Eligible Dependents information (the "Group Eligibility List"), as communicated by United and consistent with CMS requirements. The Group Eligibility List is subject to modification by United based upon acceptance or rejection of Enrollment by United and CMS.

2.02.01 Enrollment/Election.

A properly completed Enrollment form must be submitted to United by Group for each Eligible Retiree and Eligible Dependent to be enrolled in the Plan. In its discretion, United may accept a uniform group Enrollment (without individual enrollment election forms and usually in an electronic file format) if such group Enrollment is conducted pursuant to Medicare Laws and Regulations. If Group utilizes the group enrollment process to enroll its Eligible Retirees and Eligible Dependents in the Plan, Group will make available to its Eligible Retirees and Eligible Dependents the ability to opt out of the enrollment in a manner that allows its Eligible Retirees and Eligible Dependents to enroll in another plan of their choice on a timely basis and in accordance with Medicare Laws and Regulations.

2.02.02 Time of Enrollment.

All Enrollment forms shall be completed and submitted by Group to United during the Open Enrollment Period. The EOC applicable to the Plan includes information regarding Initial Enrollment Period and Special Enrollment Period, as defined by CMS, during which Eligible Retirees and Eligible Dependents may enroll in the Plan outside of the Open Enrollment Period.

Group shall forward all completed or amended Enrollment forms for receipt by United. Group acknowledges that any Enrollment form not received by United consistent with CMS timing requirements may be rejected by United or may result in a later effective date of coverage.

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2.02.03 Enrollment Notice to Eligible Retiree and Eligible Dependent.

Group shall provide a written notice, prepared by United, to Eligible Retirees and Eligible Dependents at the commencement of the Open Enrollment Period and throughout the year to persons who become eligible at times other than during the Open Enrollment Period. The written notice shall provide notice of the availability of coverage under the Plan.

2.02.04 Enrollment Record Retention.

Group's record of Member's enrollment election must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual Member, United and/or CMS, as necessary, and be maintained by Group for the term of this Addendum and for ten (10) years thereafter.

2.03 Commencement of Coverage.

The commencement date of coverage under the Plan shall be effective in accordance with the terms of this Addendum and Medicare Laws and Regulations (or, if applicable, in accordance with the eligibility date CMS communicates to United). United's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Plan Beneficiary Premium payment and CMS' confirmation of enrollment.

2.04 Involuntary Disenrollment.

In the event a Member no longer meets Group's eligibility requirements for participation in the Plan, Group and/or Member shall provide written notice to United of such Member's disenrollment from the Plan or Group shall provide notice via the monthly Group Eligibility List submission, if applicable. Such notice, regardless of medium, shall include the reason for disenrollment. Group shall notify United thirty (30) calendar days prior to the proposed effective date of disenrollment. Disenrollment generally cannot be effective prior to the date Group submits the disenrollment notice.

In the case of a Member who no longer meets Group's eligibility requirements for participation in the Plan or in the case of termination of this Addendum in accordance with Section 5, Group will issue prospective notice to Member of the termination a minimum of twenty-one (21) calendar days prior to the effective date of said termination. Such notice must advise Member of other insurance options that may be available through Group. Group will also advise such Member that the disenrollment action means the Member will not have coverage. If the Plan provides coverage for prescription drugs, the Notice must include information about the potential for late-enrollment penalties that may apply in the future.

The effective date of disenrollment always falls on the last calendar day of a month. In the case of a Member no longer meeting Group's eligibility requirements, Group will send United notice of a Member's termination from the Plan by the first calendar day of the month for an effective date of the last calendar day of that month. All notifications received after the first calendar day of the month will result in a termination effective date of the last calendar day of the following

month. Group agrees to pay any applicable Plan Beneficiary Premium through the last calendar day of the month in which Member is enrolled.

2.05 Voluntary Disenrollment.

In the event a Member elects to discontinue being covered by the Plan, United must receive a written notice signed by Member that complies with CMS requirements In the event Group submits Member voluntary disenrollment via the Group Eligibility List, Group must include in the Group Eligibility List the date Member advised Group of disenrollment. The effective date of disenrollment always falls on the last calendar day of a month. Disenrollment generally cannot be effective prior to the date Member advises Group of disenrollment or Member submits the Member's signed, written disenrollment notice. Group agrees to pay any applicable Plan Beneficiary Premium through the last calendar day of the month in which Member is enrolled.

2.06 Disenrollment Record Retention.

Group's record of Member's election to disenroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual Member, United and/or CMS, as necessary, and be maintained by Group for at least ten (10) years following the effective date of the Member's disenrollment from the Plan.

SECTION 3 - GROUP OBLIGATIONS, PLAN BENEFICIARY PREMIUM AND COPAYMENTS

3.01 Notices to Member.

If Group or United terminates this Addendum pursuant to Section 5 below, Group shall promptly notify all Members enrolled through Group of the termination of their coverage in the Plan. Such notification will include any other plan options that may be available through Group. Group shall provide such notice by delivering to each Member a true, legible copy of the notice of termination sent from United to Group, or from Group to United, at the Member's then current address. Group shall promptly provide United with a copy of the notice of termination delivered to each Member, along with evidence of the date the notice was provided. In the event that United terminates Member's enrollment in the Plan for non-payment of Plan Beneficiary Premium or United's non-renewal of this Addendum, Members will receive notice of termination from United.

If United or Group makes any changes affecting Members' benefits or obligations under the Plan, including but not limited to, increasing the Plan Beneficiary Premium payable by Member, increasing Copayments or Coinsurance or reducing Covered Services, unless the change is to be communicated by United through the Annual Notice of Change process, the party promulgating the change shall promptly notify all Members enrolled through Group of the applicable change. If Group promulgates the change and is required to provide notice to Members, Group shall provide such notice by delivering to each Member a true, legible copy of the notice of the applicable change at the Member's then current address. When required by CMS, Group shall promptly provide United with a copy of any notice delivered to each Member, along with evidence

of the date the notice was provided. United shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.01.

3.02 Plan Beneficiary Premium.

Plan Beneficiary Premium will be paid to United by the Due Date in accordance with Section 3.04 below. Group shall pay or ensure payment of any portion of Plan Beneficiary Premium for Members for which Group is responsible. Each Member is responsible for paying to United or Group, as applicable, any portion of Plan Beneficiary Premium for which he or she is responsible. When agreed by United and Group, United will bill each Member for Member's amount of the Plan Beneficiary Premium. United shall arrange for Covered Services under the Plan only for those Members for whom the applicable Plan Beneficiary Premium has been paid.

3.02.01 Late Enrollment Penalty.

Plan Beneficiary Premium may include any late enrollment penalties as determined applicable by CMS. The late enrollment penalty ("LEP") is based on the combination of a percentage of the national average Part D bid amount set by CMS and the number of months a beneficiary has not enrolled in a Medicare Part D plan, when eligible or a Member does not have creditable coverage (coverage containing a prescription drug benefit that is equivalent to Medicare Part D). The LEP is communicated to United by CMS upon confirmation of Member enrollment by CMS. In the event Member is assessed a LEP by CMS, United will bill the LEP directly to Group. Otherwise, upon Group's written authorization, United will bill the LEP directly to Member. In the case where United bills Member directly for Plan Beneficiary Premium, United will bill the LEP directly to the applicable Member.

3.03 Due Date.

Plan Beneficiary Premium is due in full on a monthly basis by check or electronic transfer and must be paid directly by Group and/or by Member, as applicable, to United on or before the first business day of the month for which the premium applies ("Due Date"). Failure to pay the PDP Plan Beneficiary Premium on or before 60 days after the Due Date may result in termination of the Member from the Plan in accordance with eligibility requirements as determined by the Group, the procedures set forth in the EOC, the RxSupplement COC and Medicare Laws and Regulations. For payments due from Group, United reserves the right to assess Group an administrative fee of five percent (5%) of the monthly premium prorated on a thirty (30)-day month for each day it is delinquent thereafter. This fee will be assessed solely at United's discretion. In the event that deposit of payments not made in a timely manner are received by United after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by United within twenty (20) business days of receipt, if United, in its sole discretion, does not reinstate Group.

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3.04 Modification of Plan Beneficiary Premium and Benefits.

3.04.01 Modification of Plan Beneficiary Premium.

Plan Beneficiary Premium may be modified by United upon thirty (30) calendar days written notice to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period.

3.04.02 Modification of Benefits or Terms.

Covered Services and Covered Part D Drugs, as set forth in the EOC, as well as other terms of coverage under the Plan may be modified by United upon thirty (30) calendar days' written notice to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period or on a later date specified in the notice.

3.05 Effect of Payment.

Except as otherwise provided in this Addendum, only Members for whom the Plan Beneficiary Premium is received by United are entitled to benefits under the Plan, and then only for the period for which such payment is received.

3.06 Adjustments to Payments.

No retroactive adjustments may be made beyond ninety (90) calendar days for any additions to or terminations of Eligible Retiree, Eligible Dependent or Member or changes in coverage classification not reflected in United's records at the time United calculates and bills for Plan Beneficiary Premium.

Any imposition of or increase in any premium tax, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to the Plan Beneficiary Premium shall be automatically added to the Plan Beneficiary Premium as of their legislative effective dates, as permitted by law. In addition, any change in law or regulation that significantly affects United's cost of operation can result in an increase in the Plan Beneficiary Premium, in an amount to be determined by United, as of the next available date of Plan Beneficiary Premium adjustment, as permitted by law.

3.07 Member/Marketing Materials.

Group shall provide United with copies of any and all materials relating to the coverage available through the Plan that Group intends to disseminate to Eligible Retiree, Eligible Dependent or Member. All materials relating to the Plan and/or United shall be subject to review and written approval by United prior to its distribution by Group. Group understands that the Plan is subject to federal and state regulatory oversight, and that Eligible Retiree, Eligible Dependent or Member materials and marketing materials (including, but not limited to, cover letters accompanying direct mail kits, announcement mailings, etc.) may be required to be filed with, reviewed and approved by, CMS or state regulators prior to use. Group agrees not to distribute such material prior to receipt of written approval of the material by United. Group shall assume all liabilities and damages arising from Group's unauthorized dissemination of Eligible Retiree, Eligible Dependent

or Member materials and/or marketing materials. Group also agrees to comply with all relevant federal and state regulatory requirements regarding the distribution and fulfillment of Eligible Retiree, Eligible Dependent or Member materials and/or marketing materials and applicable timeframes.

3.08 Compliance with the Health Insurance Portability and Accountability Act of 1996; Creditable Coverage.

United is not responsible for issuing any and all notices of creditable coverage required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to eligible Members.

3.09 Employer/Union-Only Group Part D Prescription Drug Plan Obligations.

Pursuant to Medicare Laws and Regulations, Group acknowledges and agrees to comply with the following obligations with respect to the Plan:

3.09.01 Uniform Premium Requirements:

Group may determine how much of a Member's Plan Beneficiary Premium Group will subsidize, subject to the following conditions in determining the Plan Beneficiary Premium subsidy:

a. Group can subsidize different amounts for different classes of Members in the Plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for Low Income Subsidy individuals;

b. Group cannot vary the Plan Beneficiary Premium subsidy for individuals within a given class of Members, other than as is required for the CMS-assessed late enrollment penalty; and

c. Group cannot charge a Member for prescription drug coverage provided under the Plan for more than the sum of his or her monthly Plan Beneficiary Premium attributable to basic prescription drug coverage and 100% of the monthly Plan Beneficiary Premium attributable to his or her supplemental prescription drug coverage (if any).

3.09.02 Low Income Subsidy:

For all Plan Low Income Subsidy eligible individuals:

a. United will administer Low Income Premium Subsidy (LIPS) credits. Pursuant to federal regulations, the LIPS amount must first be used to reduce the portion of the monthly Plan Beneficiary Premium attributable to basic prescription drug coverage paid by Member, with any remaining portion of the LIPS amount then applied toward the portion of the monthly Plan Beneficiary Premium attributable to basic prescription drug coverage paid by Group. If, however, United does not or cannot directly bill Group's Members, CMS will waive this up-front reduction requirement and permit United to directly refund the amount of the LIPS to the Member.

b. If the sum of Member's and Group's monthly Plan Beneficiary Premium is less than the

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amount of the LIPS credit, any amount of the LIPS credit above the total Plan Beneficiary Premium must be returned to CMS; and

c. If the LIPS credit for which a Member is eligible is less than the portion of the monthly Plan Beneficiary Premium paid by Member, Group shall communicate to Member the financial consequences for Member of enrolling in the Plan as compared to enrolling in another Medicare Part D Plan with a monthly beneficiary premium equal to or below the LIPS amount.

d. Any LIPS credit due to Member and/or Group must be applied within forty-five (45) calendar days of receipt.

e. To enable United to appropriately administer LIPS disbursements, Group shall complete and return an annual attestation issued by United.

i. The attestation validates the Group's current billing procedures and is used to determine the recipient of LIPS disbursements.

ii. The lack of an up-to-date attestation will default the disbursement of LIPS to Member regardless of prior year attestation information.

iii. United will not refund Group for LIPS disbursements made to Member during periods prior to an adequate attestation being completed and returned.

iv. In order to collect and redistribute misappropriated LIPS disbursements made to Group, United reserves the right to bill Group who has received LIPS disbursements on behalf of Member due to incorrect attestation information.

f. United shall provide reporting to Group for Members currently receiving LIPS disbursements. These reports will identify Member by name and display their respective monthly disbursements. These reports are intended to allow Group to recoup, if applicable, any remaining portion of the LIPS credit (payment that remains after the LIPS credit is used to exhaust the monthly Plan Beneficiary Premium attributable to basic prescription drug coverage paid by the Member). If the reported amount exceeds $30, the amount distributed would likely cover multiple months. Group would only be allowed to recoup the difference between the monthly Plan Beneficiary Premium and the monthly LIPS credit amount. In these cases, a request for a more detailed report from United should be sought before attempting to recoup LIPS disbursements.

SECTION 4 - RELATIONSHIPS OF AND BETWEEN PARTIES

4.01 Relationship of Parties.

United is not the agent or representative of Group. Group is not the agent or representative of United.

4.02 Roles.

United shall not be deemed or construed as an employer or as an employee for any purpose with respect to the administration or provision of benefits under Group's benefit plan. United shall not be responsible for fulfilling any duties or obligations of an employer or an employee with respect to Group's benefit plan. This Addendum is a business transaction between two unrelated parties.

SECTION 5 - TERMINATION

5.01 Termination Events

This Addendum shall terminate, in whole or in part as the case may be, for one or more of the following events and notices of termination shall be sent by United within 90 (ninety) days of the effective date of termination, or as otherwise required by CMS.

a. termination or non-renewal of United's contract with CMS;

b. termination or non-renewal with respect to a Service Area or a portion of a Service Area in which Member resides, as applicable.

c. if United no longer issues the Plan or any group health benefit plans within the applicable market, as permitted by law;

d. if Group fails to abide by and enforce the conditions of Enrollment set forth in this Addendum;

e. if Group no longer meets United's minimum contribution or participation requirements;

f. non-renewal of this Addendum by United at the end of the then current term.

g. in the event of a filing by or against the Group of a petition for relief under the Federal Bankruptcy Code,

h. any jurisdiction prohibits a party from administering the Plan under the terms of this Addendum, or imposes a penalty on the Plan, Group or United and such penalty is based on the services specified in this Addendum. In this situation, the party may immediately discontinue the Addendum's application in such jurisdiction. Notice must be given to the other party when reasonably practical. The Addendum will continue to apply in all other jurisdictions.

5.02 Termination for Nonpayment of Plan Beneficiary Premium.

United may terminate this Addendum in the event Group or its designee, or Member fails to remit Plan Beneficiary Premium, including LEP, in full by the Due Date to United by giving written notice of termination of this Addendum to Group. Nonpayment of Plan Beneficiary Premium includes, but is not limited to, payments returned due to non-sufficient funds and post-dated checks. Such notice shall specify that payment of all unpaid Plan Beneficiary Premium must be received by United within sixty (70) calendar days of the date of issuance of the notice, and that if payment is not received within the sixty (60) day period, no further notice shall be given, and coverage for all Members enrolled in this Plan shall automatically be terminated effective at the

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end of the month for which Plan Beneficiary Premium has been actually received by United, subject to compliance with notice requirements.

5.03 Termination for Providing Misleading or Fraudulent Information.

United may terminate this Addendum thirty (30) calendar days after United sends written notice to Group if Group provides materially misleading or fraudulent information to United in any Group questionnaire or is aware that materially misleading or fraudulent information has been provided on Eligible Retiree, Eligible Dependent or Member Enrollment forms.

5.04 For Loss of Group's Office Location within Service Area.

Group acknowledges that in the event of such change of Group's office location, a modification to Plan Beneficiary Premium may be necessary. In the event of a change of Group's office location, the parties shall negotiate any changes requested by either party to the Plan Beneficiary Premium. In the event that the parties are unable to reach agreement regarding modified Plan Beneficiary Premium, United may terminate Group upon thirty (30) calendar days' written notice prior to such termination.

5.05 Return of Prepayment Premium Fees Following Termination.

In the event of termination by either party (except in the case of fraud or deception in the use of United services or facilities, or knowingly permitting such fraud or deception by another), United will, within thirty (30) calendar days, return to Group the pro-rata portion of money paid to United which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to United. United's exercise of its termination rights under Section 5.02 above does not waive United's right to payment by Group for all coverage provided, including late fees as provided in Section 3.03 above.

SECTION 6 - MISCELLANEOUS PROVISION

6.01 ERISA.

United makes no representations or determinations regarding whether the arrangement contemplated by this Addendum constitutes an employee welfare benefit plan under the Employee Retirement Income Security Act ("ERISA"), 29 USC § 1001 et seq. This determination is solely the responsibility of Group. United will administer this Addendum in accordance with the requirements of Medicare Laws and Regulations and applicable state laws and is not responsible for complying with the provisions of ERISA or administering any applicable obligations that may arise under ERISA, including those relating to claims procedures or appeals, providing summary plan descriptions, required filings, member materials or disclosures. United is neither the plan administrator nor named fiduciary of the employee benefit welfare plan, as those terms are used in ERISA.

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Company #: 1115849

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

OFFICE OF THE LIEUTENANT GOVERNOR

Division of Banking, Insurance, and Financial Regulation

Certificate of Authority

This is to certify that in accordance with the Virgin Islands Code, which provides for the regulation of the business of Insurance in the Virgin Islands,

UnitedHealthcare Insurance Company

185 Asylum Street Hartford CT 06103

having filed all the documents required by law and having otherwise complied with the applicable insurance laws of the U.S. Virgin Islands is hereby authorized to transact the type(s) of insurance listed below:

Life
Disability
Accident
Health

NOW, THEREFORE, I **Tregenza A. Roach Esq.** Lieutenant Governor and Commissioner of Insurance, pursuant to the authority vested in me in Section 209 of the Title 22 Virgin Islands Code, hereby issue this Certificate Of Authority which authorizes said Company to transact the type(s) of insurance set forth above.

This certificate is valid from January 01, 2023 to December 31, 2023. Renewal of this Certificate is required annually upon expiration on the 31st day of December, and it may be suspended or revoked as provided in Section 212 of Title 22 Virgin Islands Code.

Given under the Seal of the Government of the Virgin Islands of the United States, at Charlotte Amalie, St. Thomas.

TREGENZA A. ROACH ESQ.
Lieutenant Governor / Insurance Commissioner

Company #: 511540187

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES
OFFICE OF THE LIEUTENANT GOVERNOR
Division of Banking, Insurance, and Financial Regulation

Certificate of Authority

This is to certify that in accordance with the Virgin Islands Code, which provides for the regulation of the business of Insurance in the Virgin Islands,

Sierra Health and Life Insurance Company, Inc.

2720 North Tenaya Way Las Vegas NV 89128

having filed all the documents required by law and having otherwise complied with the applicable insurance laws of the U.S. Virgin Islands is hereby authorized to transact the type(s) of insurance listed below:

Accident
Health

NOW, THEREFORE, I **Tregenza A. Roach Esq.** Lieutenant Governor and Commissioner of Insurance, pursuant to the authority vested in me in Section 209 of the Title 22 Virgin Islands Code, hereby issue this Certificate Of Authority which authorizes said Company to transact the type(s) of insurance set forth above.

This certificate is valid from January 01, 2023 to December 31, 2023. Renewal of this Certificate is required annually upon expiration on the 31st day of December, and it may be suspended or revoked as provided in Section 212 of Title 22 Virgin Islands Code.

Given under the Seal of the Government of the Virgin Islands of the United States, at Charlotte Amalie, St. Thomas.

TREGENZA A. ROACH ESQ.
Lieutenant Governor / Insurance Commissioner

THE UNITED STATES VIRGIN ISLANDS
OFFICE OF THE LIEUTENANT GOVERNOR

DIVISION OF
BANKING, INSURANCE AND
FINANCIAL REGULATION

January 10, 2023

Ms. Michelle Campbell
Senior Regulatory Analyst
Sierra Health and Life Ins. Co., Inc.
P O Box 36451
Las Vegas, NV 89133

Re: 2023 Certificate of Authority.

Dear Ms. Campbell:

Enclosed is the Certificate of Authority issued **Sierra Health and Life Insurance Company, Inc.** or "Company". The Certificate authorizes the Company to conduct insurance business in the United States Virgin Islands. The Certificate of Authority is for Calendar year 2023 and is subject to the following conditions but not limited to:

1. Pursuant to Section 222 of Title 22 Virgin Islands Code, the Company must file annually with the Division of Banking and Insurance ("Division"), an annual statement for each calendar year on or before March 31st of the following year. Such statement must be submitted in general form and context as approved by the National Association of Insurance Commissioners (NAIC). The annual statement must include a Statement of Actuarial Opinion on Page 1 and must be issued by a certified actuary. In addition, a filing fee of $250.00 must accompany the statement as provided in Section 601, Title 22 of the Virgin Islands Code. The Company is also required to include a VI State Page when submitting their annual statements.

2. Pursuant to Section 222a of Title 22, the Company must have an annual audit prepared by an independent certified public accountant. Such audited financial report must be filed with the Commissioner of Insurance, on or before June 01st of each year for the year ending December 31st immediately preceding. A filing fee of $25.00 must accompany the audited reported as provided in Section 601 of Title 22, Virgin Islands Code.

3. The Company's Certificate of Authority expires on December 31st of each year and it should be renewed on or before said date to avoid any applicable penalties. The fee for the renewal of your license is $600.00.

4. Pursuant to Act 7963 (Title 22 Chapter 20), all Domestic Insurance Companies are required to submit a **Risk Based Capital Report** annually on or before March 1st of each year with a filing fee of $25.00 pursuant to section 601 Title 22 of Virgin Islands Code. **This filing requirement is only for Domestic insurers.** However, it can be requested by the Division for Foreign insurers.

5. Pursuant to Title 22 of the Virgin Islands Code Section 498(C), all insurers **domiciled** in the Territory and all **alien insurers** doing business in the Territory that are **not licensed to conduct insurance business in any other U.S. Jurisdiction** are required to file a Corporate Governance Annual Disclosure on or before June 1st of each year. A filing fee of $25.00 must accompany the document.

6. Pursuant to Title 22 of the Virgin Islands Code Section 486, all insurers **domiciled** in the Territory, all **foreign** insurers that are **not subject to the requirements and standards as adopted by statute substantially similar to those contained in Title 22, Chapter 20a of the Virgin Islands Code** and all **alien** insurers **not licensed to transact insurance in at least one other U.S. Jurisdiction** are required to file an Own Risk and Solvency Assessment ("ORSA") Summary Report on or before March 15th of each year. A filing fee of $25.00 must accompany the document.

7. The Company must maintain at all times its statutory deposit of $500,000. If it's a Title Company, a statutory deposit of $100,000 must be maintained.

8. The Company is required to file a supplement to the annual statement titled "Management's Discussion and Analysis" by April 1st of each year, along with a filing fee of $25.00. This supplement is primarily a narrative document setting forth information which enables regulators to enhance their understanding of the insurer's financial position, results of operations, changes in capital and surplus accounts and cash flow. The narrative may refer to such schedules, exhibits, General Interrogatives and Five-Year Historical Data contained in the annual statement as management believes to be necessary. Please apply to the NAIC Accounting Instructions for guidance.

9. The Company is required to file a supplement to the annual statement titled "Accident and Health Policy Experience Exhibit" by April 1st of each year, along with a filing fee of $25.00. Please apply to the NAIC for guidance. **This filing is only required if the Company sells accident and health policies.**

10. Pursuant to Section 603 of Title 22 Virgin Islands Code, all premium tax filings are due quarterly, March, June, September and December, with filing dates on or before the first day of February, May, August and November of each year. The filing for each statement is $50.00. Enclosed is a Quarterly Statement forms for said filings.

11. The Company must submit to the Division quarterly financial statements no later than sixty (60) days after the end of each quarter. A filing fee of $25.00 must accompany each filing.

12. On or before March 15th of each year, the Company shall file with the Commissioner of Insurance a confidential document entitled "Actuarial Opinion Summary". The Company's appointed actuary must provide the summary separate and apart from the statement of Actuarial Opinion. In addition, the summary must be clearly labeled and identified as a confidential document. A filing fee of $25.00 is required. **This summary filing is only required for Property and Casualty Insurance Companies.**

13. All policy forms, rates amendments and other related changes must be filed for approval with this office with the appropriate filing fee of $20.00 per form. These forms can be submitted thru SERFF. If submitted electronically, you must be notified of approval by the Division before they can be used to do business in the Territory.

14. The Company must designate contact persons to facilitate communication between our office and the Company. Therefore, the Company must keep the contact information current during the time it is licensed in the Virgin Islands.

15. The Company is required to submit Biographical Affidavits for any new appointed Directors and/or Officers to the Company along with a filing fee of $25.00 each. **Only submit for those that are added to the company Jurat page.**

16. Premiums written to stated capital should not exceed the recommended NAIC ratio of 3-to-1.

17. The Company is required to keep on file a written Catastrophe Response Plan with the Division. If you have already submitted your plan and changes have been made, please submit an updated copy for your file and if no changes were made since your last submittal, there is no need to resubmit.

18. The Company must remain in sound financial condition during the time it engages in insurance business in the Virgin Islands. The Financial soundness of the company shall be subject to strict scrutiny and if the Commissioner of Insurance has reason to believe that the Company's financial condition is unsound, its Certificate of Authority may be revoked.

19. The Company must comply with the laws of the Virgin Islands, and other insurance related laws; and the violation of said laws may result in the revocation of the Company's Certificate of Authority.

Please feel free to contact the Division regarding any of the above mentioned.

Sincerely,

Condaisy Richards
Insurance Licensing Examiner

ASSISTANT SECRETARY'S CERTIFICATE

I, Heather Lang, the undersigned, hereby certify as follows:

1. That I am the Assistant Secretary of Sierra Health and Life Insurance Company, Inc., a Nevada corporation (hereinafter the "Corporation").

2. That attached hereto as Exhibit A is a true, correct and complete copy of the Sierra Health Services, Inc. Schedule to Delegation of Authority Policy (the "DOA Policy") resolutions duly adopted by the Board of Directors of the Corporation by Written Consent on December 31, 2009.

3. That the Board of Directors of the Corporation has, and at the time of the adoption of the resolutions had, full power and lawful authority to adopt the resolutions and to confer the powers thereby granted to the titles therein named, who have full power and lawful authority to exercise the same.

4. That pursuant to the duly adopted Policy, Michael J. Grossman, Chief Operating Officer and the duly elected Director of the Corporation, is authorized to sign agreements related to the provision of the Medicare products and services on behalf of the Corporation.

5. That Michael J. Grossman has authority to sign documents on behalf of the Corporation relating to Medicare products and services.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of July, 2022.

Heather A. Lang
Assistant Secretary

EXHIBIT A

Adoption of Sierra Health Services, Inc.'s Schedule to the UnitedHealth Group Delegation of Authority Policy

WHEREAS, on December 18, 2009, the Corporation's parent company, Sierra Health Services, Inc., adopted a new Schedule to the UnitedHealth Group Delegation of Authority Policy; and

WHEREAS, the Corporation shall adopt the same Schedule to the Delegation of Authority Policy as its parent company.

NOW, THEREFORE, BE IT RESOLVED, that the Board hereby adopts the attached Sierra Health Services Schedule to the UnitedHealth Group Delegation of Authority Policy effective as of the date first written above.

FURTHER RESOLVED, that the officers of the Corporation are hereby authorized to take any and all actions necessary or appropriate to accomplish the intent and purpose of the foregoing resolution.

FURTHER RESOLVED, that all actions heretofore taken by the officers of the Corporation in connection with the above resolutions are hereby ratified, approved and made the acts and deeds of the Corporation.

Sierra Health Services, Inc. Schedule to the UnitedHealth Group Delegation of Authority Policy

STATEMENT OF PURPOSE

The following Financial Compliance Controls and Delegation of Authority Protocol (the "Policy") shall be implemented for Sierra Health Services, Inc. and its subsidiaries ("Sierra").

The purpose of this Policy is to ensure that Sierra complies with UnitedHealth Group Incorporated's ("UHG" or the "Company") policies and procedures relating to compliance with the Sarbanes-Oxley Act, Delegation of Authority principles and other applicable laws and regulations.

This Policy is in place to ensure that all employees follow certain standards and rules when making decisions about binding UHG to a specific course of action, and when making payments on behalf of the Company. The Policy has two components:

- **Binding Authority:** Binding authority is the authority to approve a transaction committing the Company, including any of its businesses, to a current or future action with potential legal, financial, compliance, strategic, or operational implications. This includes contracts, contract amendments, contract addendums, master services agreements, binding requests for proposal, and any other written agreement creating a commitment for UHG.

- **Payment Authority:** Payment authority is the ability to approve invoices or otherwise pay third parties (e.g., check or wire transfer) with Company funds.

DELEGATED AUTHORITY LEVELS

UHG has the authority to act, enter into agreements and bind the Company for routine transactions relevant to their business. Authority is formally delegated down through the organization, starting with the CEO of UHG, then to the CEO's direct reports, and then through leadership into the Business Groups, Segments, and Functional Areas. Authority is delegated to employees ("Authorizers") through the organization based on titles, roles or positions. Binding authority for the Sierra Health Services, Inc. and its subsidiaries ("Sierra") include the following:

Class	Category	Authority
Administration	Community Giving Commitments	Authorized
	Human Resources	Authorized
	Political Contributions	Authorized
Compliance	Legal Agreements	Authorized
	Litigation	Authorized
	Provider Settlements (non-litigation)	Authorized
	Regulatory	Authorized
Finance	Capital Structure	No Authorization
	Financial Arrangements/ Transactions	Authorized
	Insurance	Authorized
	Investments	Authorized
	Real Property	Authorized
	Securities/Dividends	Authorized
	Tax	Authorized
Governance	Corporate Governance/ Policies	Authorized
	External Auditor Services (includes non-audit)	No Authorization
	Internal Auditor Services	No Authorization
Operations	Customer Agreements	Authorized
	Event Management	No Authorization
	InterSegment Agreements	Authorized
	Inventory	Authorized
	Provider Network	Authorized
	Purchasing/Supplier Management Contracts	Authorized
Strategic	External Relationships	Authorized
	M&A	Authorized
	New Lines of Business (outside of ordinary course)	Authorized

The following binding and payment authorization levels are delegated to Sierra:

Title (all titles are for the UHC Nevada Market)	Approval Limit
President/CEO	5,000,000
Sr Vice President & COO	2,000,000
Sr Executive Vice President, Legal	1,000,000
Sr Vice President, Information Systems & CIO	250,000
Sr. Vice President, Provider Relations	250,000
Sr Vice President, Clinical Operations	250,000
Chief Medical Officer & Pharmacy Director	250,000
Sr. Vice President, Sales & Marketing	250,000
Vice President, Operations	250,000
Vice President, Vice President, Medical Affairs	250,000
Assistant General Counsel, Legal	250,000
Chief Financial Officer, Finance	250,000
Vice President, Client Services	125,000
Sr Vice President, Human Resources Operations	125,000
Sr. Vice President, Public & Community Relations	125,000
Chief Actuary, Actuarial Services	100,000
Assistant Vice President, Tax Services	100,000

All other employees Grade 29 and above will follow UHG's approval limits. Any approval limit changes will follow the sub-delegation procedures.

Binding authorization is limited to authorized classed and categories listed in the table on page two. For binding authority, these approval limits are for annual dollar amounts of the binding document.

INTER-COMPANY TRANSACTIONS

Inter-company transactions between two or more UHG legal entities must maintain the same *arms-length bargaining* as contracts entered into between UHG and a third-party. Accordingly, in a written contract between two or more UHG legal entities, an authorizer, either directly or through delegation, can only sign on behalf of one UHG legal entity. In most cases, there is a legal requirement to obtain prior approval from State Insurance Departments, 30 days in advance of the effective date, for any inter-company agreements or amendments and material transactions between UHG subsidiaries when one of the subsidiaries is an HMO or insurance company. Please contact the legal department for assistance with any arrangements that may fall into this category.

SUB-DELEGATION

There are certain times when a delegate may be unavailable or determine that a subordinate should have binding authority capacity given their position and the need to execute business efficiently. In these cases, delegates may sub-delegate their authority to another person within their reporting structure. All sub-delegations must be to an individual, and submitted for approval to the Office of Ethics and Integrity using the submission process found on the Frontier Web site. A sub-delegation is not effective until a sub-delegation request submitted via the Web site has been:

1. Completed by the delegate requesting sub-delegation rights fro another employee;
2. Submitted to and approved by the Office of Ethics & Integrity; and
3. Initiated based on the dates included in the request.

Authorizers or Sub-Delegates retain their authority until the earlier of:

1. Board action terminating such authority;
2. Senior officer action terminating such authority;
3. Employee leaving the position within which the authority is delegated/sub-delegated; or
4. Business reorganization eliminating the Sub-Delegate's responsibility for the transaction for which authority was sub-delegated.

SPECIAL APPROVAL CONSIDERATIONS

In addition, certain transactions require Corporate Subject Matter Expert approval. Examples include real estate purchases and engaging certain outside vendors. Additional approval considerations are listed below. Just like all other approvals, these approvals must be obtained and retained in writing.

- **Non-Standard & M&A Documents:** Generally, most letters of intent, letters of agreement, contracts, purchase orders, leases, guarantees and other legally binding documents must be reviewed and approved by the Business Segment's, Business Unit's or Corporate Department's Legal Services Department. Most business areas use a variety of standard documents, such as provider agreements, policies and benefit contracts, licenses, purchase orders, etc., that have already been approved by their Legal Services Department. Once the standard document is developed, Legal Services Department review of party-specific documents is required only if the document deviated from the approved standard form. Each business area should work with its Legal Services Department to implement review procedures whenever appropriate. All mergers, acquisitions, and divestitures require the participation of the Legal department.

- **Indebtedness:** Incurring any indebtedness for borrowed money or guarantee any such indebtedness of another person or issue, guaranteeing any debt securities of another person, entering into any "keep well" or other agreement to maintain any financial statement

condition of another person or enter into any arrangement having the economic effect of any of the foregoing or (B) making any loans, advances or capital contributions to, or investments in, any other person except for loans, advances, capital contributions and investments (1) in or to any direct or indirect wholly owned subsidiary of Sierra or (2) made in the ordinary course of business consistent with past practice

- **International Transactions:** Transactions for products or services outside of the United States must be reviewed and approved by subject matter experts from various areas, depending on the nature of the transaction. Representatives from Public Communications, Global Sourcing, International, Human Capital, Treasury, Tax, Insurance Risk Management , Real Estate, Procurement, Legal/local Legal subject matter experts, Information Technology/Security, Business Risk Management, Business Continuity/Disaster Planning, Ethics & Integrity, Telecommunications, and senior management responsible for oversight of the impacted business(es) must be engaged and sign off on the transaction. This is to ensure that risks unique to the particular geography, including logistical, people, environmental, political, monetary, legal, strategic, and others can be identified and mitigation strategies developed for consideration in the business case. Decisions to close international offices due to an emergency event do not require Human Capital approval due to language or geographical barriers as this time.

- **Leases:** Business managers should contact Procurement before entering into any non real-property lease financing transactions. Procurement will work with the business manager to ensure that appropriate finance, treasury, tax and legal resources are engaged with segment business leaders to evaluate, negotiate and approve the lease transaction. All real property lease financing transactions must be executed through UnitedHealth Group Real Estate.

- **Customer Agreements:** Any loss contract must be approved by the UnitedHealth Group CFO.

- **Master Services Agreements:** When contracting with vendor/supplier, please be aware that a Master Services Agreement may already be in place for existing business UnitedHealth Group has with that vendor/supplier. Therefore, please check with Procurement, or UHG IT Procurement for technology vendors/suppliers, to determine if such an agreement already exists. If a master services agreement is in place, you are required to coordinate with the owner of the vendor/supplier relationship to comply and align with the existing master service agreement when drafting any new agreements.

APPROVAL EVIDENCE AND RETENTION

Authorizations must be documented in writing and retained by the transaction Authorizer for one year beyond duration of the agreement. Formal signoff is

required, documented in writing via an e-mail, memo letter or other written documentation.

All employees are expected to be familiar with the Delegation of Authority that affects their area. Periodic reviews and audits to determine compliance with the Delegation of Authority Policy will be conducted or overseen by the Office of Ethics & Integrity. Review findings or other issues related to compliance will be escalated to the appropriate senior management and communicated to the impacted business area for remediation.

OTHER

Consistent with UHG's Sarbanes-Oxley, Delegation of Binding Authority and related compliance policies and procedures, the foregoing policy is intended to give UHG's approval authority with respect to transactions or actions committing Sierra to a current or future action with potential legal, compliance or material financial implications. This authority, except as required for compliance with policies and procedures related to compliance with laws and regulations, shall not be utilized to unduly influence, direct or control the management of Sierra with regard to any aspect of its operations, and shall be implemented so as to ensure that the management of Sierra acts to maintain its current marketplace approach, including but not limited to, claims payment and claims adjudication practices and providing services to Nevada's underserved communities, including Medicare and Medicaid markets, and the offering and renewing of individual and small group products.

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
GESC/HEALTH INSURANCE
BOARD OF TRUSTEES
P.O. Box 11177
St. Thomas, Virgin Islands 00801

August 29, 2023

Honorable Albert Bryan Jr.
Governor of the Virgin Islands
Government House
Nos. 21-22 Kongens Gade
St. Thomas, VI 00802

RE: Justification Letter – GESC/Health Insurance Board of Trustees UnitedHealthcare Medicare Retirees Renewal effective January 1, 2024

Dear Governor Bryan:

The Government Employees Service Commission (GESC) Health Insurance Board of Trustees ("Board") acting as the sole body overseeing the operation of the Government employees' health and other benefit plans, has recently secured bids with UnitedHealthcare after completing a Request for Proposals (RFP) for competitive bids as required by statute for insurance services last year which included Medical and Prescription Drug coverage for active employees and retirees, Employee Assistance Program, Dental, Vision, Life and Accidental Death & Dismemberment (AD&D) plans.

UnitedHealthcare was the only insurer who responded to the post-65 retiree coverage and maintains a competitive advantage in the Territory being licensed to offer a group Medicare Advantage plan.

UnitedHealthcare began its partnership with the Government in 2013 offering their AARP Medicare Supplement plans alongside a custom Medicare Part D Prescription Drug Plan (PDP). The plans offered significant savings to the Government and retirees. Over the years we have worked with UnitedHealthcare to ensure a long term and sustainable program for the Government and retirees.

In 2017, the Board recommended to offer the stateside retiree's two Medicare Advantage Plans with Prescription Drug Coverage (MAPD) which further reduced costs to the Government and eased administrative burdens while maximizing benefits for stateside retirees. This proved to be extremely successful with a smooth transition and a retiree satisfaction score of 95%.

For 2021, UnitedHealthcare received approval for the Territorial retirees to participate in the group Medicare Advantage plan offered by UnitedHealthcare which covers everything covered by original Medicare with additional benefits including health and wellness, routine vision checks, hearing checks, podiatry, chiropractic, and prescription drugs.

All post-65 retirees are covered by one plan regardless of if they are Territorial residents or Stateside residents. Coverage is nationwide and retirees are not required to select a Primary Care Physician (PCP) and referrals are not required to see a Specialist.

The proposed rate to the existing plan offered today is a 20% increase above current premiums or an increase of $3.8 million for the 2024 calendar year. This reflects changes and updates from the 2024 Final Call Notice on March 31, 2023. The Final Call Notice had significant changes to growth rates, Part C Risk Adjustment Model Changes, and Part C Risk Adjustment Coding which negatively impacted the funding insurance companies receive from CMS for 2024.

The Board, through our consultant, Gehring Group was able to negotiate an option that would eliminate a fiscal impact to both the Government and retirees' paychecks. To achieve a no increase in premiums we are recommending adding a $500 deductible which is the same deductible amount as the pre-65 retiree plan. Also there will be a $250 per inpatient hospital admission copayment and a $100 emergency room copayment. Protecting the retirees is a $1,000 annual out-of-pocket maximum. Making these changes will save $588 per post-65 retiree per year.

It is important to note that the deductible does not apply to Primary Care Office Visits, Telemedicine Visits, Emergency Room Visits, Urgent Care Visits, Diabetic Monitoring Supplies, Hospice, Preventive Visits, Vision and/or Hearing Visits.

Premiums are submitted for regulatory approval to both CMS and the USVI Department of Insurance and the monthly premium has been approved effective January 1, 2024, through December 31, 2024, at no increase. The monthly premium will be $250.24 per person per month. Based on current cost-share the Governments portion of the premium would be $12,908,120 and the retirees portion would be $6,649,638.

There have been some additional program enhancements included for 2024 at no additional cost to continuously care for our retirees:

- UnitedHealthcare Hearing Aide Enhancements
    - Retirees can utilize their hearing aide allowance to purchase non-prescription (over the counter) hearing aids through UHC Hearing. Retirees can save thousands of dollars making hearing aides more accessible and affordable.
- Continuous Glucose Monitors (CGMs)
    - CGMs provide users with real-time information about their blood glucose levels around the clock, leading to better diabetes management and improved health outcomes. The coverage criteria for CGMs has been expanded to more retirees with diabetes who are not just dependent on insulin and now also includes those with certain hypoglycemia conditions.
- Let's Move
    - A wellness program coordinated and designed to integrate self-service, virtual and in-person wellness programming focused on nutrition, physical activity, mental health, social well-being, financial wellness and more.

- Marriage and Family Therapy
    - Retirees will be able to see Medicare eligible mental health counselors (MHCs) and marriage and family therapists (MFTs).

In addition, Medicare Retirees will continue to receive a quarterly Grocery Store Benefit. Retirees will receive a $40 credit each quarter to spend locally on healthy food and over-the-counter products. They can choose from a variety of approved items like fruits, vegetables, dairy, meat, pain relievers, cold remedies, vitamins and more. Credits are added to a debit card on the first day of each quarter (in January, April, July, and October) and expire at the end of the year.

HouseCalls will also continue for 2024 which allows our retirees to have a yearly visit with a healthcare practitioner right in the privacy of their own home. It's a great opportunity for members to discuss their health care needs, create a plan for prevention and get the personal attention they deserve. During the visit, the practitioner will confirm medical history, complete a physical exam, review medications, and answer any questions the retiree may have as well as provide any additional health screenings the practitioner deems necessary.

Also, UnitedHealthcare will continue to offer $200,000 to their Wellness Incentive Fund which will allow the GESC and the Government to provide wellness incentives and initiatives for our Medicare Retirees.

The Board believes it was able to obtain the overall lowest cost for both the Government, and its retirees, while maintaining a viable benefit offering.

Sincerely,

Beverly A. Joseph
Chairperson, GESC/Health Insurance Board of Trustees

pc: GESC Health Insurance Board Members
Cindy Richardson, Director of Personnel
Valerie Clarke-Daley, Chief, Group Health Insurance
Carol McDonald Esq., Legal Counsel
Gehring Group Consultant

Government of The Virgin Islands of the United States
Central Government & GERS Group Health Projected Budget
Fiscal Year: October 1, 2023 - September 30, 2024

GEHRING GROUP
A RISK STRATEGIES COMPANY

Plan	Coverage Type	Enrollment	2022-2023 Estimated FY Total Premium	2022-2023 Estimated FY Employer Share	2022-2023 Estimated FY Employee Share	2023-2024 Projected FY Total Premium	2023-2024 Projected FY Employer Share	2023-2024 Projected FY Employee Share
Active Employees								
Medical	Employee	3,307	$ 38,214,898	$ 27,896,876	$ 10,318,023	$ 38,214,898	$ 27,896,876	$ 10,318,023
	Family	3,755	$ 75,873,830	$ 55,387,896	$ 20,485,934	$ 75,873,830	$ 55,387,896	$ 20,485,934
Dental	Employee	3,307	$ 786,537	$ 589,903	$ 196,634	$ 786,537	$ 589,903	$ 196,634
	Family	3,722	$ 2,258,212	$ 1,693,659	$ 564,553	$ 2,258,212	$ 1,693,659	$ 564,553
Life	Basic	7,848	$ 170,459	$ 170,459	$ -	$ 95,118	$ 95,118	$ -
	Voluntary	5,827	$ 2,123,357	$ -	$ 2,123,357	$ 2,123,357	$ -	$ 2,123,357
	Spouse	1,198	$ 115,473	$ -	$ 115,473	$ 115,473	$ -	$ 115,473
	Child(ren)	2,610	$ 20,984	$ -	$ 20,984	$ 20,984	$ -	$ 20,984
Vision	Employee	5,154	$ 244,918	$ -	$ 244,918	$ 244,918	$ -	$ 244,918
	Family	3,721	$ 466,167	$ -	$ 466,167	$ 466,167	$ -	$ 466,167
TOTAL - Active Employees			**$ 120,274,835**	**$ 85,738,792**	**$ 34,536,043**	**$ 120,199,495**	**$ 85,663,451**	**$ 34,536,043**
$ Amount Increase/(Decrease)						**$ (75,341)**	**$ (75,341)**	**$ -**
% Amount Increase/(Decrease)						**-0.1%**	**-0.1%**	**0.0%**
Retirees								
Under 65 Medical	Retiree	773	$ 11,581,272	$ 8,454,328	$ 3,126,943	$ 11,581,272	$ 8,454,328	$ 3,126,943
	Retiree Dependents	374	$ 5,603,358	$ 4,090,451	$ 1,512,907	$ 5,603,358	$ 4,090,451	$ 1,512,907
	Family	577	$ 15,450,768	$ 11,279,060	$ 4,171,707	$ 15,450,768	$ 11,279,060	$ 4,171,707
Over 65 Medical	Medicare Advantage	6,513	$ 19,557,757	$ 12,908,120	$ 6,649,638	$ 19,557,757	$ 12,908,120	$ 6,649,638
Dental	Retiree	4,874	$ 1,159,198	$ 869,399	$ 289,800	$ 1,159,198	$ 869,399	$ 289,800
	Family	1,900	$ 1,152,595	$ 864,446	$ 288,149	$ 1,152,595	$ 864,446	$ 288,149
Life	Basic	8,242	$ 659,195	$ 659,195	$ -	$ 331,328	$ 331,328	$ -
	Voluntary	6,466	$ 7,017,974	$ -	$ 7,017,974	$ 7,017,974	$ -	$ 7,017,974
	Spouse	1,428	$ 563,825	$ -	$ 563,825	$ 563,825	$ -	$ 563,825
	Child(ren)	485	$ 3,899	$ -	$ 3,899	$ 3,899	$ -	$ 3,899
Vision	Retiree	1,061	$ 50,419	$ -	$ 50,419	$ 50,419	$ -	$ 50,419
	Family	346	$ 43,347	$ -	$ 43,347	$ 43,347	$ -	$ 43,347
TOTAL - Retirees			**$ 62,843,606**	**$ 39,124,999**	**$ 23,718,607**	**$ 62,515,739**	**$ 38,797,133**	**$ 23,718,607**
$ Amount Increase/(Decrease)						**$ (327,867)**	**$ (327,867)**	**$ -**
% Amount Increase/(Decrease)						**-0.5%**	**-0.8%**	**0.0%**
TOTAL - Active Employees & Retirees			$ 183,118,442	$ 124,863,791	$ 58,254,650	$ 182,715,234	$ 124,460,584	$ 58,254,650
$ Amount Increase/(Decrease)						$ (403,208)	$ (403,208)	$ -
% Amount Increase/(Decrease)						-0.2%	-0.3%	0.0%

Notes:

A. Projected Budget assumes Actual Premium Rates Negotiated in GESC RFP No. 2023-01.

B. Over 65 Medical is 9-months of the fiscal year (effective January 1, 2024).

1. Estimated FY Total Premium may vary based upon actual enrollment for the remainder of current Fiscal Year & proposed Fiscal Year.

2. Costs account for Senate funded subsidies of member contributions for FY2019-2020; FY2020-2021; FY2021-2022; & FY2022-2023.

UnitedHealthcare Group Medicare Advantage (PPO)

Government of the United States Virgin Islands

Medical $500 Ded / Medical $1,000 OOP

Medical Coverage (Deductible and OOP Max apply to medical services only)

Benefit Name	In Network Services	Out of Network Services	MOOP	DED
Annual Medical Deductible	$500	$500	Y	
Is Annual Medical Deductible combined for IN and OUT of network?	Yes			
Annual Medical Out-of-Pocket Maximum	$1,000	$1,000		
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes			
Physician Services				
Primary Care Physician Office Visit (includes Non-MD office visits)	$0	$0	Y	
Specialist Office Visit	$0	$0	Y	Y
Telemedicine	$0	$0	Y	
Annual Routine Physical Exam	$0	$0	Y	
Inpatient Services				
Inpatient Hospital Stay	$250 Per Admit	$250 Per Admit	Y	Y
Skilled Nursing Facility Care - Prior hospital stay requirement waived	Yes	Yes		
Skilled Nursing Facility Care - Benefit Period	100 Days			
Skilled Nursing Facility Care	$0 Per Day Days 1 - 100	$0 Per Day Days 1 - 100	Y Y	Y Y
Inpatient Mental Health Lifetime Maximum	190 Days			
Inpatient Mental Health/ Substance Abuse in a Psychiatric Hospital	$0 Per Admit	$0 Per Admit	Y	Y
Outpatient Services				
Outpatient Surgery	$0	$0	Y	Y
Outpatient Hospital Services	$0	$0	Y	Y
Outpatient Mental Health/Substance Abuse - Individual Visit	$0	$0	Y	Y
Outpatient Mental Health/Substance Abuse - Group Visit	$0	$0	Y	Y
Partial Hospitalization (Mental Health Day Treatment) per day	$0	$0	Y	Y
Comprehensive Outpatient Rehabilitation Facility (CORF)	$0	$0	Y	Y
Occupational Therapy	$0	$0	Y	Y
Physical Therapy and Speech/Language Therapy	$0	$0	Y	Y
Cardiac/Intensive Cardiac/Pulmonary Rehabilitation/SET	$0	$0	Y	Y
Intensive Cardiac Rehabilitation	$0	$0	Y	Y
Pulmonary Rehabilitation	$0	$0	Y	Y
Supervised Exercise Therapy (SET) for Symptomatic peripheral artery disease (PAD)	$0	$0	Y	Y
Kidney Dialysis	$0	$0	Y	Y
Medicare Covered Services				
Chiropractic Visit	$0	$0	Y	Y
Podiatry Visit	$0	$0	Y	Y
Eye Exam	$0	$0	Y	Y
Eyewear (Frames and Lenses after cataract surgery)	$0	$0	Y	
Hearing Exam	$0	$0	Y	Y
Dental Services	$0	$0	Y	Y
Ambulance/Emergency Room/Urgent Care				
Ambulance Services	$0	$0	Y	Y
Ambulance Copay Waived if Admitted	No	No		

Medical $500 Ded / Medical $1,000 OOP

Medical Coverage (Deductible and OOP Max apply to medical services only)				
Benefit Name	In Network Services	Out of Network Services	MOOP	DED
Ambulance/Emergency Room/Urgent Care				
Emergency Room (includes Worldwide coverage)	$100	$100	Y	
Emergency Room Copay Waived if Admitted within 24 hours	Yes	Yes		
Urgent Care (Includes Worldwide Coverage)	$0	$0	Y	
Urgent Care Copay Waived if Admitted within 24 hours	Yes	Yes		
Part B Drugs And Blood				
Part B Drugs	$0	$0	Y	Y
Part B Chemotherapy Drugs	$0	$0	Y	Y
Blood (3 pint deductible waived)	$0	$0	Y	
Durable Medical Equipment (DME) And Supplies				
Durable Medical Equipment	$0	$0	Y	Y
Prosthetics	$0	$0	Y	Y
Orthotics	$0	$0	Y	Y
Diabetic Shoes and Inserts	$0	$0	Y	Y
Medical Supplies	$0	$0	Y	Y
Diabetic Monitoring Supplies	$0	$0	Y	
Insulin Pumps and Supplies	$0	$0	Y	Y
Home Healthcare Agency & Hospice				
Home Health Services	$0	$0	Y	Y
Hospice (Medicare-covered)	$0	$0	Y	
Procedures				
Clinical Laboratory Services	$0	$0	Y	Y
Outpatient X-ray Services	$0	$0	Y	Y
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	$0	$0	Y	Y
Diagnostic Radiology Service	$0	$0	Y	Y
Therapeutic Radiology Service	$0	$0	Y	Y
Preventive Services (Medicare-Covered)				
Cardiovascular Screenings	$0	$0	Y	
Immunizations (Flu, Pneumococcal, Hepatitis B)	$0	$0	Y	
Pap Smears and Pelvic Exams	$0	$0	Y	
Prostate Cancer Screening	$0	$0	Y	
Colorectal Cancer Screenings	$0	$0	Y	
Bone Mass Measurement (Bone Density)	$0	$0	Y	
Mammography	$0	$0	Y	
Diabetes - Self-Management Training	$0	$0	Y	
Medical Nutrition Therapy and Counseling	$0	$0	Y	
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0	$0	Y	
Smoking Cessation Visit	$0	$0	Y	
Abdominal Aortic Aneurysm (AAA) Screenings	$0	$0	Y	
Diabetes Screening	$0	$0	Y	
HIV Screening	$0	$0	Y	
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0	$0	Y	
Screening for Depression in Adults	$0	$0	Y	

Medical $500 Ded / Medical $1,000 OOP

Medical Coverage (Deductible and OOP Max apply to medical services only)				
Benefit Name	In Network Services	Out of Network Services	MOOP	DED
Screening for Sexually Transmitted Infections (STIs) and high intensity Behavioral Counseling to prevent STIs	$0	$0	Y	
Intensive Behavioral Therapy to reduce Cardiovascular Disease Risk	$0	$0	Y	
Screening and Counseling for Obesity	$0	$0	Y	
Glaucoma Screening	$0	$0	Y	
Kidney Disease Education	$0	$0	Y	
Dialysis Training	$0	$0	Y	
Hepatitis C Screening	$0	$0	Y	
Lung Cancer Screening	$0	$0	Y	
Additional Benefits/Non-Medicare Covered Services				
Podiatry (Non-Medicare Covered)				
Podiatry	$0	$0		Y
Podiatry - Number of Visits	6 Visits			
Vision (Non-Medicare Covered)				
Eye Exam Refraction	$0	$0		
Hearing (Non-Medicare Covered)				
Hearing Exam for Hearing Aids	$0	$0		
Hearing Exam - Number of Visits	1 Visit			
Hearing Exam - Benefit Period	1 Year			
Hearing Aid - Device Allowance	$500			
Hearing Aid - Allowance Per Ear or Combined	Combined			
Hearing Aid - Number of Devices	Unlimited			
Hearing Aid - Benefit Period	3 Years			
Wellness/Clinical Programs				
Health and Food Products Benefit Program - OTC and Food Products Card - Members are provided $40 each quarter, rolls over to $160 annual allowance to purchase approved groceries and over-the-counter products at approved locations.	**Included**			
Digital Wellness Coaching Programs including: • **Wellness Coaching** blended model of personal coaching, self-paced online learning and digital support across a variety of wellbeing topics such as healthy eating, sleep management, and more. • **Quit For Life tobacco cessation program** using an evidence-based combination of physical, psychological and behavioral strategies to help members overcome their addiction to tobacco. • **Real Appeal:** two digital weight loss programs: Real Appeal Weight Loss Support and Real Appeal Diabetes Prevention.	**Included**			
Fitness Program	**Included**			
Preferred Diabetic Supply Program	**Included**			
HouseCalls Program	**Included**			
Member Rewards Program - Reward cards for completing certain health care activities	**Included**			
Let's Move Program - A wellness program coordinated and designed to integrate self-service, virtual and in-person wellness programming focused on physical activity, mental health, social well-being, financial wellness and more.	**Included**			

Medical $500 Ded / Medical $1,000 OOP

Wellness/Clinical Programs	
UHC Hearing Aid Discount Program - Available services and offerings may be limited in the U.S. Territories	**Included**
Case and Disease Management, including: - High Risk Members - Heart Failure - Respiratory Illness - Kidney Disease - Diabetes - Behavioral Health - Nurse Support - 24/7	**Included**

Outpatient Prescription Drug Coverage (Medical Deductible & Medical OOP Max do NOT apply)	
Prescription Drug Plan	Custom
Pharmacy Network	Broad Network
Formulary	Standard Formulary H (Group Select Formulary)
Bonus Drug List	List U
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On
Benefit Name	**In Network Services**
Custom OOP, ICL, Catastrophic	
Initial Coverage Limit	$5,030
True Out of Pocket Threshold (TrOOP)	$8,000
Catastrophic Coverage over TrOOP	2024 CMS Standard - Member pays:
Copay for generics	$0
Copay for all other drugs	$0
Day Supply Information	
Retail 1 month supply	30
Retail 2 month supply	60
Retail 3 month supply	90
Mail Order 1 month supply	30
Mail Order 2 month supply	60
Mail Order 3 month supply	90
Part D Gap Coverage	
Part D Gap Coverage	Full Coverage

Tier Definitions	
Tier 1 - Preferred Generic	All covered generic drugs
Tier 2 - Preferred Brand	Many common brand name drugs, called preferred brands
Tier 3 - Non-preferred Drug	Non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in tier 3.
Tier 4 - Specialty Tier	Unique and/or very high-cost brand drugs

Part D Retail		
1 month supply		
Tier 1	Preferred Generic	$10
Tier 2	Preferred Brand	$40
Tier 3	Non-preferred Drug	50% ($95 Max)
Tier 4	Specialty Tier	50% ($95 Max)
2 month supply		
Tier 1	Preferred Generic	$20
Tier 2	Preferred Brand	$80
Tier 3	Non-preferred Drug	50% ($190 Max)
Tier 4	Specialty Tier	50% ($190 Max)
3 month supply		
Tier 1	Preferred Generic	$30
Tier 2	Preferred Brand	$120
Tier 3	Non-preferred Drug	50% ($285 Max)
Tier 4	Specialty Tier	50% ($285 Max)

Medical $500 Ded / Medical $1,000 OOP

Outpatient Prescription Drug Coverage (Medical Deductible & Medical OOP Max do NOT apply)		
Part D Mail Order		
1 month supply		
Tier 1	Preferred Generic	$10
Tier 2	Preferred Brand	$40
Tier 3	Non-preferred Drug	50% ($95 Max)
Tier 4	Specialty Tier	50% ($95 Max)
2 month supply		
Tier 1	Preferred Generic	$20
Tier 2	Preferred Brand	$80
Tier 3	Non-preferred Drug	50% ($190 Max)
Tier 4	Specialty Tier	50% ($190 Max)
3 month supply		
Tier 1	Preferred Generic	$20
Tier 2	Preferred Brand	$80
Tier 3	Non-preferred Drug	50% ($190 Max)
Tier 4	Specialty Tier	50% ($190 Max)

Learn more about the UnitedHealthcare® Group Medicare Advantage (PPO) plan extra benefits and programs

As a UnitedHealthcare Medicare Advantage plan member, you get all the benefits of original Medicare, plus additional benefits and some great extra programs.

HouseCalls — Enjoy a preventive care visit in the privacy of your own home

With UnitedHealthcare® HouseCalls, you get a yearly in-home visit from one of our health care practitioners at no extra cost. A HouseCalls visit is designed to support, but not take the place of your regular provider's care.

Every visit includes tailored recommendations on health care screenings and a chance to:

- Review current medications
- Receive education, prevention tips, care and resource assistance, if needed
- Get advice and ask questions on how to manage health conditions
- Receive referrals to other health services and more
- At the end of the visit, our health care practitioner will leave a personalized checklist and send a summary to your regular doctor

To schedule your HouseCall, call toll-free **1-866-447-7868**, TTY **711**, 8 a.m.–8:30 p.m. ET, Monday–Friday.

HouseCalls may not be available in all areas.

24/7 Nurse Support

Speak to a registered nurse 24/7 about your medical concerns at no additional cost to you. Call toll-free **1-877-365-7949**, TTY **711**, 24 hours a day, 7 days a week.

United Healthcare

Teladoc®

With Teladoc, you're able to live video chat[1] with a provider from your computer, tablet or smartphone — any time, day or night. **You may want to prepare ahead by setting up an account for a Teladoc Visit so you're all set when it's time to make an appointment.** You can register for Teladoc by visiting **www.uhcvirtualvisits.com** and then selecting "choose a medical provider". You also can download the Teladoc app using your smartphone or tablet.

Virtual Teladoc Visits

Getting sick is never convenient. When you don't feel well, you may not be able to leave your home to go to the provider's office. With Teladoc you can ask questions, get a diagnosis or even get medication prescribed and have it sent to your pharmacy. All you need is a strong internet connection. Teladoc visits may be good for minor health concerns like:

- Allergies, bronchitis, cold/cough
- Fever, seasonal flu, sore throat
- Migraines/headaches, sinus problems, stomachaches
- Bladder/urinary tract infections, rashes

This service should not be used for emergency or urgent care needs. In an emergency, call **911** or go to the nearest emergency room

UnitedHealthcare Fitness Program

Renew Active® is the gold standard in Medicare fitness programs for body and mind, available at no additional cost. Work out where you want, whether that's at a gym or fitness location or from your home. You'll receive a free gym membership with access to our nationwide network of gyms and fitness locations. This includes access to many premium gyms, on-demand digital workout videos and live streaming classes, social activities and access to an online Fitbit® Community for Renew Active and access to an online brain health program from AARP® Staying Sharp® (no Fitbit device is needed).

To learn more and get your unique confirmation code, call toll-free **1-866-827-9022,** TTY **711,** 8 a.m.–8 p.m. ET, Monday–Friday, or visit **www.UHCRetiree.com/GVI.**

Rally Coach Programs

Start living a healthier, happier life with help from the Rally Coach™ programs:

- Real Appeal® Weight Loss and Real Appeal Diabetes Prevention*, online weight loss programs designed to help you gain energy, reduce your risk of developing serious health conditions and achieve your long-term health goals
- Wellness Coaching, an online and live coaching support program that provides access to a variety of digital health and wellness courses
- Quit for Life®, a tobacco cessation program providing access to the tools and resources you need to help you quit all types of tobacco use

Get started today at **rallyhealth.com/retiree.**

For Real Appeal, call **1-844-924-7325,** Monday–Friday, 6 a.m.–10 p.m. CT.
For Rally Wellness Coaching, call **1-800-478-1057,** TTY **711,** 7 a.m.–10 p.m. CT, Monday–Thursday, 7 a.m.–7 p.m. CT, Fridays, 8 a.m.–4:30 p.m. CT, Saturdays.
For Quit for Life, call **1-866-QUIT-4-LIFE,** TTY **711,** 24 hours a day 7 days a week.

Renew — Go beyond the plan benefits to help you live your best life

We all want to live a healthier, happier life and Renew by UnitedHealthcare® can be your guide. Renew, our member-only online Health & Wellness Experience, includes:

- Inspiring lifestyle tips, coloring pages, recipe library, streaming music
- Interactive quizzes and tools
- Learning courses, health news, articles & videos, health topic library
- Rewards

As a UnitedHealthcare member, you can explore all that Renew has to offer by logging in to **www.UHCRetiree.com/GVI.**

UnitedHealthcare Hearing — Hear the moments that matter most with custom-programmed hearing aids

Your hearing health is important to your overall well-being and can help you stay connected to those around you. With UnitedHealthcare Hearing, you'll get access to hundreds of name-brand and private-labeled hearing aids — available in-person at any of our 7,000+ UnitedHealthcare Hearing providers nationwide[3] or delivered to your doorstep with direct delivery and virtual care (select products only) — so you'll get the care you need to hear better and live life to the fullest.

Learn more at **www.uhchearing.com/retiree** or call toll-free **1-866-445-2071,** TTY **711,** 9 a.m.–9 p.m. ET, Monday–Friday.

Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider.

Network size varies by local market.

Healthy Benefits Plus

Take advantage of a $40 credit every 3 months to spend on approved healthy food and over-the-counter (OTC) health and wellness products.

- Buy healthy foods like fruits and vegetables, meat, seafood, dairy products and water.
- Choose from over-the-counter products like vitamins, pain relievers, toothpaste, or cough drops.

You can use your card at any network location once coverage begins. To check your balance or find a network provider, call **1-866-757-2158** or visit **HealthyBenefitsPlus.com/USGVI**.

Food and OTC benefits have expiration timeframes. Call your plan or review your Evidence of Coverage (EOC) for more information.

[1]The device you use must be webcam-enabled. Data rates may apply.

[2]Based on gym and fitness location network size.

[3]Please refer to your Summary of Benefits for details on your benefit coverage.

*Refer to the Evidence of Coverage for eligibility requirements.

Real Appeal is available at no additional cost to UnitedHealthcare members on this insurance plan with a BMI of 19 and higher, subject to eligibility.

Rally Coach™ programs The information provided through the program is for informational purposes only and provided as part of your health plan. It is educational in nature and should not substitute for medical advice. Rally and the Rally logo(s) are registered trade and service marks of Rally Health, Inc. ©2021 Rally Health, Inc. All rights reserved.

Participation in the Renew Active® program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership and other offerings. Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, discounts, classes events, and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. AARP Staying Sharp is the registered trademark of AARP. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan.

Renew by UnitedHealthcare is not available in all plans. Resources may vary.

The Telephonic Nurse Support should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

This information is not a complete description of benefits. For more information, please call our Customer Service toll-free at 1-866-827-9022, TTY 711 8 a.m.–8 p.m. ET, Monday–Friday. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

ROSS MILLER
Secretary of State
204 North Carson Street, Suite 4
Carson City, Nevada 89701-4520
(775) 684-5708
Website: www.nvsos.gov

040102

Filed in the office of	Document Number
Ross Miller Secretary of State State of Nevada	00003786944-81
	Filing Date and Time 01/22/2013 10:40 AM
	Entity Number E0032912013-6

Articles of Incorporation
(PURSUANT TO NRS CHAPTER 78)

USE BLACK INK ONLY - DO NOT HIGHLIGHT — ABOVE SPACE IS FOR OFFICE USE ONLY

1. Name of Corporation: SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

2. Registered Agent for Service of Process: (check only one box)
- [X] Commercial Registered Agent: THE CORPORATION TRUST COMPANY OF NEVADA (Name)
- [ ] Noncommercial Registered Agent (name and address below) OR [ ] Office or Position with Entity (name and address below)

Name of Noncommercial Registered Agent OR Name of Title of Office or Other Position with Entity

Street Address — City — Nevada — Zip Code

Mailing Address (if different from street address) — City — Nevada — Zip Code

3. Authorized Stock: (number of shares corporation is authorized to issue)
Number of shares with par value: 250,000 — Par value per share: $ 14.40 — Number of shares without par value:

4. Names and Addresses of the Board of Directors/Trustees: (each Director/Trustee must be a natural person at least 18 years of age; attach additional page if more than two directors/trustees)
1) DONALD JAMES CIANCURSIO (Name)
2720 NORTH TENAYA WAY (Street Address) | LAS VEGAS (City) | NV (State) | 89128 (Zip Code)
2) SCOTT GORDON CASSANO (Name)
2720 NORTH TENAYA WAY (Street Address) | LAS VEGAS (City) | NV (State) | 89128 (Zip Code)

5. Purpose: (optional; see instructions)
The purpose of the corporation shall be:
To engage in any lawful act or activity including transacting life insurance and health insurance

6. Name, Address and Signature of Incorporator: (attach additional page if more than one incorporator)
DONALD JAMES CIANCURSIO (Name) — X (Incorporator Signature)
2720 NORTH TENAYA WAY (Address) | LAS VEGAS (City) | NV (State) | 89128 (Zip Code)

7. Certificate of Acceptance of Appointment of Registered Agent:
I hereby accept appointment as Registered Agent for the above named Entity.
X Michele Miller Assistant Secretary — Jan. 2., 2013
Authorized Signature of Registered Agent or On Behalf of Registered Agent Entity — Date

This form must be accompanied by appropriate fees.

Nevada Secretary of State NRS 78 Articles
Revised: 3-10-11

ATTACHMENT TO
ARTICLES OF INCORPORATION
OF
SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

The Articles of Incorporation of Sierra Health and Life Insurance Company, Inc. (the "Corporation") consist of the Articles set forth on the prior page and continued on this Attachment as well as the additional Articles set forth on this Attachment as follows:

4. (continued from previous page)

ADDITIONAL DIRECTORS

3) Robert Lee Schaich

2720 North Tenaya Way, Las Vegas, NV 89128

4) Marc R Briggs

2720 North Tenaya Way, Las Vegas, NV 89128

5) Frank Edwin Collins

2720 North Tenaya Way, Las Vegas, NV 89128

6) Laurence Stanley Howard

2720 North Tenaya Way, Las Vegas, NV 89128

7) Christopher Lockett Hard

2525 Lake Park Blvd., Salt Lake City, UT 84120

6. (continued from previous page)

ADDITIONAL INCORPORATORS

2) Robert Lee Schaich

2720 North Tenaya Way, Las Vegas, NV 89128

3) Scott Gordon Cassano

2720 North Tenaya Way, Las Vegas, NV 89128

8. OFFICERS

1) Donald James Giancursio, PRESIDENT
2) Glen Wendell Stevens, SECRETARY
3) Sachin Dehnanedra Shah, TREASURER

The aggregate number of shares that the Corporation shall have authority to issue is Two Hundred Fifty Thousand (250,000) shares of common stock, $14.40 par value per share (the "Common Stock"). All shares of Common Stock must be issued at a price not less than par value.

SECRETARY OF STATE

STATE OF NEVADA

CORPORATE CHARTER

I, ROSS MILLER, the duly elected and qualified Nevada Secretary of State, do hereby certify that **SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.**, did on January 22, 2013, file in this office the original Articles of Incorporation; that said Articles of Incorporation are now on file and of record in the office of the Secretary of State of the State of Nevada, and further, that said Articles contain all the provisions required by the law of said State of Nevada.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on January 22, 2013.

ROSS MILLER
Secretary of State

Certified By: Patricia Isaman
Certificate Number: C20130122-0620
You may verify this certificate online at **http://www.nvsos.gov/**

ROSS MILLER
Secretary of State
204 North Carson Street, Suite 4
Carson City, Nevada 89701-4520
(775) 684-5708
Website: www.nvsos.gov

140501

Filed in the office of	Document Number
Ross Miller Secretary of State State of Nevada	20130038529-63
	Filing Date and Time 01/22/2013 10:40 AM
	Entity Number E0032912013-6

Articles of Domestication
(PURSUANT TO NRS 92A.270)

USE BLACK INK ONLY - DO NOT HIGHLIGHT — ABOVE SPACE IS FOR OFFICE USE ONLY

1. Entity Name and Type of Domestic Entity as set forth in its Constituent Documents:	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., A CALIFORNIA CORPORATION AUTHORIZED TO TRANSACT LIFE AND DISABILITY INSURANCE
2. Entity Name Before Filing Articles of Domestication:	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
3. Date and Jurisdiction of Original Formation:	AUGUST 17, 1906 CALIFORNIA
4. Jurisdiction that Constituted the Principal Place of Business, Central Administration or Equivalent of the Undomesticated Entity Immediately Before Articles of Domestication:	NEVADA
5. Signature of Authorized Representative:	X _____ Authorized Signature Jan 2, 2013 Date

Filing Fee: $350.00

IMPORTANT: ***This document must be accompanied by the appropriate constituent document for the type of domestic entity described in article 1 above and the filing fees.***

This form must be accompanied by appropriate fees.

State of California
Secretary of State

CERTIFICATE OF STATU

Filed in the office of	Document Number
Ross Miller Secretary of State State of Nevada	20130038522-96
	Filing Date and Time 01/22/2013 10:40 AM
	Entity Number E0032912013-6

ENTITY NAME:

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

FILE NUMBER:	C0047270
FORMATION DATE:	08/17/1906
TYPE:	DOMESTIC CORPORATION
JURISDICTION:	CALIFORNIA
STATUS:	ACTIVE (GOOD STANDING)

I, DEBRA BOWEN, Secretary of State of the State of California, hereby certify:

The records of this office indicate the entity is authorized to exercise all of its powers, rights and privileges in the State of California.

No information is available from this office regarding the financial condition, business activities or practices of the entity.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of January 14, 2013.

Debra Bowen

DEBRA BOWEN
Secretary of State

NP-25 (REV 1/2007)

PAM

BRIAN SANDOVAL
Governor

STATE OF NEVADA

TERRY JOHNSON
Director

SCOTT J. KIPPER
Commissioner

Filed in the office of	Document Number
Ross Miller Secretary of State State of Nevada	20130038526-30
	Filing Date and Time 01/22/2013 10:40 AM
	Entity Number E0032912013-6

DEPARTMENT OF BUSINESS AND INDU
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.state.nv.us

January 2, 2013

State of Nevada
Secretary of State
101 North Carson Street, Ste. 3
Carson City, NV 89701

Re: Sierra Health and Life Insurance Company, Inc.
NV Org. # 944, NAIC # 71420
Approval of: Articles of Incorporation
Articles of Domestication
The word "Insurance" in name of insurer

To Whom It May Concern:

Please be advised that the State of Nevada, Division of Insurance approves the submission of the Articles of Incorporation, Articles of Domestication and the use of the word 'insurance' in the name of the insurer, *Sierra Health and Life Insurance Company, Inc.*

If you have any questions or comments, please do not hesitate to contact me. My phone number is (775) 687-0758 and my e-mail address is mlynch@doi.nv.gov.

Sincerely,

Michael Lynch
Deputy Commissioner
Division of Insurance

ML:ksl