

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
MONTGOMERY, ALABAMA

REPORT OF EXAMINATION

OF

UNITEDHEALTHCARE OF ALABAMA, INC.

Birmingham, Alabama

AS OF

DECEMBER 31, 2013

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EXAMINER AFFIDAVIT

**STATE OF ALABAMA
COUNTY OF MONTGOMERY**

Blase Francis Abreo, CFE, being duly sworn, states as follows:

1. I have authority to represent Alabama in the examination of UnitedHealthcare of Alabama, Inc.
2. Alabama is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.
3. I have reviewed the examination workpapers and examination report, and the examination of UnitedHealthcare of Alabama, Inc. was performed in a manner consistent with the standards and procedures required by the State of Alabama.

The affiant says nothing further.

Francis Blase Abreo
Blase Francis Abreo

Subscribed and sworn before me by Francis Blase Abreo on this 7th day of April, 2015.

(SEAL)

Tusha RF Johns
Notary Public

My Commission expires 10/12/15



ROBERT BENTLEY
GOVERNOR

JIM L. RIDLING
COMMISSIONER

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
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DEPUTY COMMISSIONER
CHARLES M. ANGELL (acting)
CHIEF OF STAFF
RAGAN INGRAM
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
EDWARD S. PAULK
GENERAL COUNSEL
REYN NORMAN

April 7, 2015

Honorable Jim L. Ridling
Commissioner of Insurance
State of Alabama
Department of Insurance
Post Office Box 303350
Montgomery, Alabama 36130-3350

Dear Commissioner Ridling:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners, a full scope financial and market conduct examination as of December 31, 2013, has been made of

UnitedHealthcare of Alabama, Inc.

at its office located at 185 Asylum Street, City Place, Hartford, Connecticut 06103.
The report of examination is submitted herewith.

Where the description "the Company" appears herein, without qualification, it will be understood to indicate **UnitedHealthcare of Alabama, Inc.**

EQUAL OPPORTUNITY EMPLOYER

SCOPE OF EXAMINATION

The Company was last examined for the three-year period ended December 31, 2010. A targeted limited scope examination was conducted for the period January 1, 2011 through April 30, 2012, which was centered on producers licensing and the appointment of producers. The current examination covers the intervening period from January 1, 2011 through December 31, 2013. The examination was coordinated with the examination of the following four companies: 1) United Healthcare of New York Inc., 2) United Healthcare Insurance Company of New York, 3) Unimerica Life Insurance Company of New York Inc. and 4) Health Net Insurance of New York Inc. The Alabama Department of Insurance relied on the examination work performed as part of the coordinated examination by New York Department of Financial Services. Alabama examiners performed mandatory procedures for the Alabama Company and determined compliance with Alabama Laws and regulation, and reviewed prospective risks specific to the Alabama Company. Where deemed appropriate, transactions, activities and similar items subsequent to December 31, 2013, were reviewed specific to the Alabama Company.

The examination was conducted in accordance with applicable statutory requirements of the State of Alabama for Health Maintenance Organizations as provided for in Title 27, Chapter 21A and in accordance with Alabama Insurance Department regulations and bulletins in addition to the procedures and guidelines promulgated by the National Association of Insurance Commissioners (NAIC), as deemed appropriate, and in accordance with generally accepted examination standards and practices.

The examination was conducted in accordance with the NAIC Financial Condition Examiners Handbook. The examination was planned and performed to evaluate the financial condition of the Company as of December 31, 2013, and to identify the prospective risks by obtaining information about the Company including corporate governance. In addition, the examination was planned and performed to identify and assess inherent risks within the Company, and to evaluate system controls and procedures used to mitigate those risks. The examination also included assessing the principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements, management's compliance with statutory accounting principles and annual statement instructions.

An examination of the Company's Information Technology General Controls (ITGC) and automated application controls systems was performed by the ITGC specialist appointed by New York Department of Financial Services. The ITGC specialist work included the review of the planning information and an assessment of application controls, logical and physical security controls, changes in application controls, system and program development controls, contingency planning controls, service provider controls, operation controls, processing controls, and network and internet controls.

A market conduct examination was performed concurrently with the financial examination. The market conduct examination included a review of the Company's territory, plan of operation, policy forms, rates and underwriting practices, advertising and marketing, claims payment practices, policyholder complaints, compliance with producers' licensing requirements, and privacy standards. See the caption "**MARKET CONDUCT ACTIVITIES**" - Page 33

The Company's annual statements for each year under examination were compared with or reconciled to the corresponding general ledger account balances.

During the examination period, the Company was audited annually by Deloitte & Touche LLP, Minneapolis, Minnesota, certified public accountants (CPA's). The CPA's workpapers were reviewed for all years under examination and were used in the examination as deemed appropriate by the examiners.

A signed certificate of representation was obtained during the examination. In this certificate, management attested to having valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2013. A signed letter of representation was also obtained at the conclusion of the examination, whereby management represented that, through the date of this examination report, complete disclosure was made to the examiners regarding asset and liability valuation, financial position of the Company, and contingent liabilities.

ORGANIZATION AND HISTORY

The information contained in this section of the examination report was excerpted from the prior examination report as of December 31, 2010 and updated as appropriate.

The Company was founded in April 1985, as a joint venture between the Medical Advancement Foundation, an affiliate of the University of Alabama Health Sciences Foundation, and certain individual businessmen. The Company was incorporated as a Health Maintenance Organization (HMO), as defined in ALA. CODE § 27-21A-1(7) (1975), on April 5, 1985, as “Complete Health, Inc.,” a for-profit Company.

On November 15, 1989, with the approval of the Alabama Department of Insurance, the shareholders of the Company transferred their stock to United HealthCare South, Inc. (formerly known as Complete Health Services, Inc.), thereby making the Company a wholly-owned subsidiary of United HealthCare South, Inc. (UHC-South).

A change in the ultimate control of the Company occurred in May of 1994, when UHC-South, the parent, merged with United HealthCare Corporation (UHC Corp). On April 30, 1996, United HealthCare Services, Inc. (UHS), an HMO management corporation and a wholly-owned subsidiary of UHC Corp, purchased UHC-South for its net book value from UHC Corp. UHS became the sole shareholder of UHC-South.

Effective May 1, 1996, the name of the Company was changed from “Complete Health, Inc.” to “United HealthCare of Alabama, Inc.” Also on that date, the Company’s wholly-owned subsidiary, Complete Health of Alabama, Inc., changed its name to “United HealthCare of Alabama-FQ, Inc.” (UHC AL-FQ).

On January 2, 1998, UHC-South merged into UHS, whereby UHS became the sole shareholder of the Company. On December 31, 1998, UHC AL-FQ merged into the Company, with the Company being the surviving entity. Since the Company and UHC AL-FQ were under common control, the transaction was accounted for as a “pooling of interest.” As of June 30, 2000, UHS contributed its common stock of the Company to UnitedHealthcare, Inc.

On May 9, 2005, the Alabama Insurance Commissioner granted approval, retroactive to January 1, 2004, to maintain the Company’s executive and principal operations offices and its usual operations records in the State of Minnesota through December 31, 2006. An amendment to the agreement was filed by the Company and approved by the Alabama Insurance Commissioner on October 29, 2008, so that the Company could continue to maintain its office and records in Minnesota through December 31, 2011. Beginning January 1, 2012, the Company was granted approval to maintain its executive office, books and records at the Company’s corporate headquarters located at 5901 Lincoln Drive, Edina, MN 55436, on a permanent basis.

At December 31, 2013, the Company's Annual Statement reflected the following:

<u>Description</u>	<u>Shares issued</u>	<u>Outstanding</u>	<u>Amount</u>
Common Capital Stock @ \$0.11 per share	927,074	912,074	\$ 100,328
Preferred Stock @ \$0.01 per share	2,000,000	2,000,000	20,000
Treasury Stock		15,000	-56,250

In addition to the capital stock, the Company reported \$17,563,520 of gross paid in and contributed surplus, and \$44,792,336 of unassigned funds (surplus).

Line of Business/Operations

At December 31, 2013 the Company's Annual Statement reflected the following:

<u>Line</u>	<u>Net Premium</u>	<u>% of business</u>
	<u>Income</u>	
Comprehensive (hospital & medical)	\$ 3,965,976	0.98
Medicare Supplement	1,923,585	0.48
Title XVIII Medicare	<u>398,631,323</u>	<u>98.54</u>
TOTAL	\$ <u>404,520,884</u>	<u>100.00</u>

As noted above, 98.541% of the net premium income is from the Title XVIII Medicare program. The Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage (Medicare Part D program) under a contract with the Centers for Medicare and Medicaid Services (CMS). Medicare Supplement netted 0.48% in premiums income and Comprehensive (commercial business) netted 0.98% in premium income.

MANAGEMENT AND CONTROL

Stockholders

At December 31, 2013, the Company was wholly-owned by UnitedHealthcare, Inc., a Delaware corporation and a wholly-owned subsidiary of United HealthCare Services, Inc. (UHS). UHS is a Minnesota corporation and a wholly owned subsidiary of UnitedHealth Group Incorporated (UHG). UHG is a Minnesota corporation and the ultimate parent corporation in the insurance holding company system.

Board of Directors

The following directors were elected by the sole shareholder and were serving on the Board of Directors on December 31, 2013:

<u>Name and Residence</u>	<u>Principal Occupation</u>
Russell Conrad Petrella*	President and Chief Executive Officer of the Company.
New York, New York	
Timothy John Noel	Chief Financial Officer of the Company
Minneapolis, Minnesota	
Glen John Golemi	President Commercial Services Group
Covington, Louisiana	Advanced Healthcare Solutions, Inc.
Catherine Eggers Palmier M.D.	Chief Medical Officer
Duluth, Georgia	UnitedHealth Group Inc.
Robert James Friedrichs#	Chief Financial Officer, Southeast Region, United Healthcare Services, Inc.
Alpharetta, Georgia	
Cheryl Ann Lippert	Chief of Staff, Southeast Region, United Healthcare Services, Inc.
Jacksonville Beach, Florida	

*Resigned on April 30, 2014 and replaced by Mr. Dennis Patrick O'Brien

#Removed effective April 18, 2014 and replaced by Mr. Stephen Lewis Wilson

Officers

The following officers were elected by the Board of Directors and were serving as officers of the Company on December 31, 2013.

<u>Officer</u>	<u>Title</u>
Russell Conrad Petrella*	President and Chief Operating Officer
Nyle Brent Cottington	VP, Regulatory Controller and Assistant Treasurer
Michelle Marie Huntley Dill	Assistant Secretary
Timothy Gilbert Caron	Assistant Secretary
Christina Regina Palme-Krizak	Secretary
John Joseph Matthews	Assistant Secretary
Timothy John Noel	Chief Financial Officer
Juanita Bolland Luis	Assistant Secretary
Robert Worth Oberrender	Treasurer
Glen John Golemi	Vice President, Commercial Services Group
Thomas Shaun McGlinch	Assistant Treasurer
Paul Timothy Runice	Assistant Treasurer
John William Kelly	Vice President, Tax Services

*Resigned on April 30, 2014 and replaced by Mr. Dennis Patrick O'Brien

CONFLICT OF INTEREST

The conflict of interest policy used by the Company was established by UnitedHealth Group Incorporated, a publicly traded Minnesota holding company. The policy requires that employees avoid conflicts of interest and outlines the process and requirements for disclosing and addressing potential conflict. At the time of hire, employees must disclose any real or potential conflict of interest to the Compliance and Ethics Officer. If during the course of the employment, a conflict of interest situation arises, employees are required to disclose the real or potential conflict to the supervisor and the Compliance and Ethics Office. In addition certain employees are required to participate in an annual survey addressing conflicts of interest conducted by the Compliance and Ethics Office.

The Conflict of Interest Statements signed by the directors and officers for the years 2011 - 2013, were reviewed by the examiners. The disclosures made by the officers and directors of the Company appeared not to be in conflict with the Alabama laws and regulations.

CORPORATE RECORDS

The Company's Articles of Incorporation, related amendments and By-laws were inspected and found to provide for the operation of the Company in accordance with usual corporate and applicable statutes and regulations. There were no changes to the Articles of Incorporation or By-laws during the period under examination.

Minutes of meetings of the Stockholders, Board of Directors and Southeast Region Audit Committee were reviewed for the period under examination. The minutes appeared to be complete with regard to recorded actions taken on matters before the respective bodies for deliberation and action.

HOLDING COMPANY AND AFFILIATE MATTERS

Holding Company Registration

The Company is not subject to the Alabama Insurance Holding Regulatory Act, as defined in ALA. CODE § 27-29-1 (1975), except as expressly required by other statutes and regulations. Generally, HMOs are subject to regulation in regard to changes in control, but are not subject to the continuing holding company reporting requirements that apply to insurance companies.

The Company is a wholly-owned subsidiary of UnitedHealthcare, Inc., a Delaware holding company. The Company is also an indirect wholly-owned subsidiary of United HealthCare Services, Inc., a Minnesota healthcare management company that is wholly-owned by UnitedHealth Group Incorporated, a publicly traded (NYSE: UNH) Minnesota holding company.

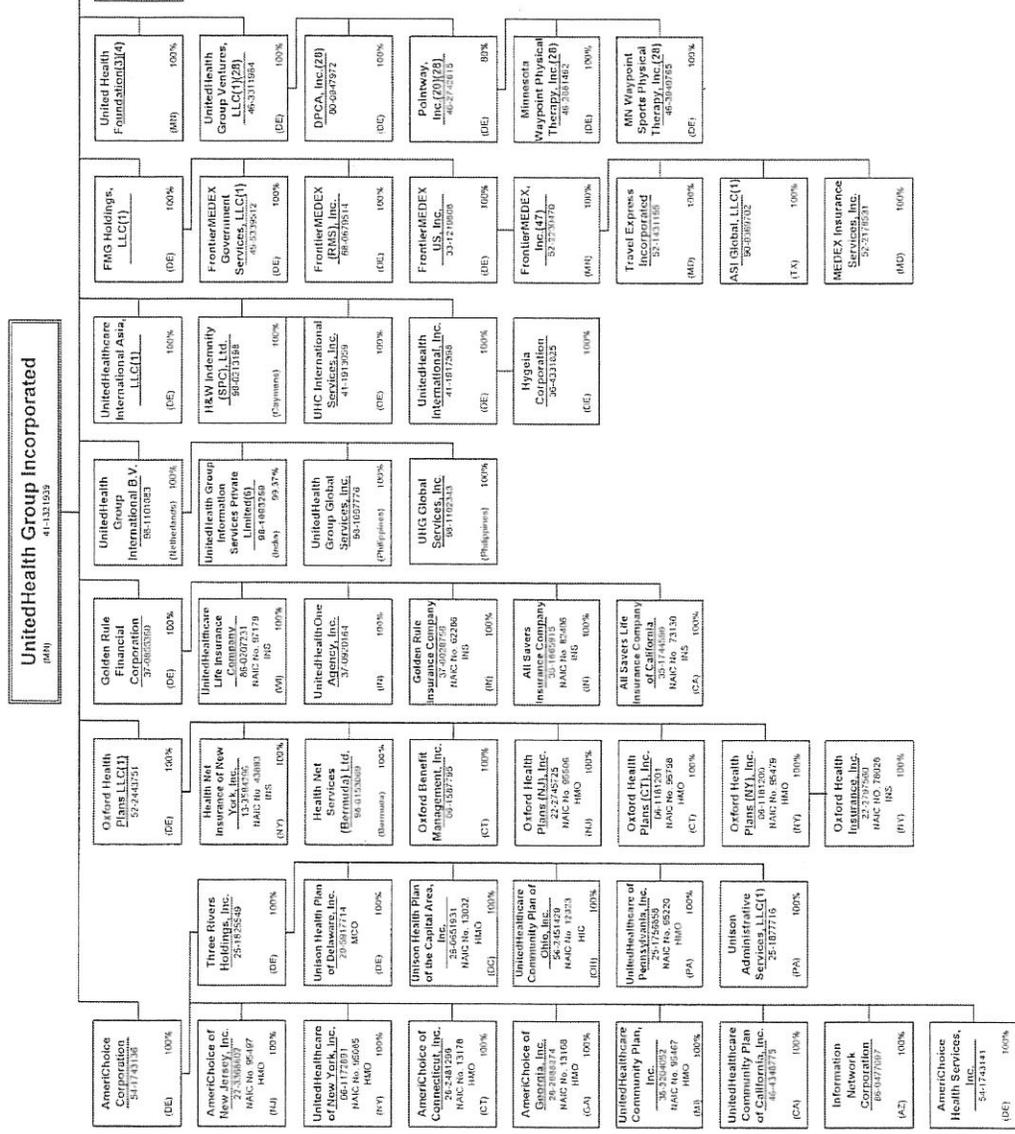
Dividends to Stockholders

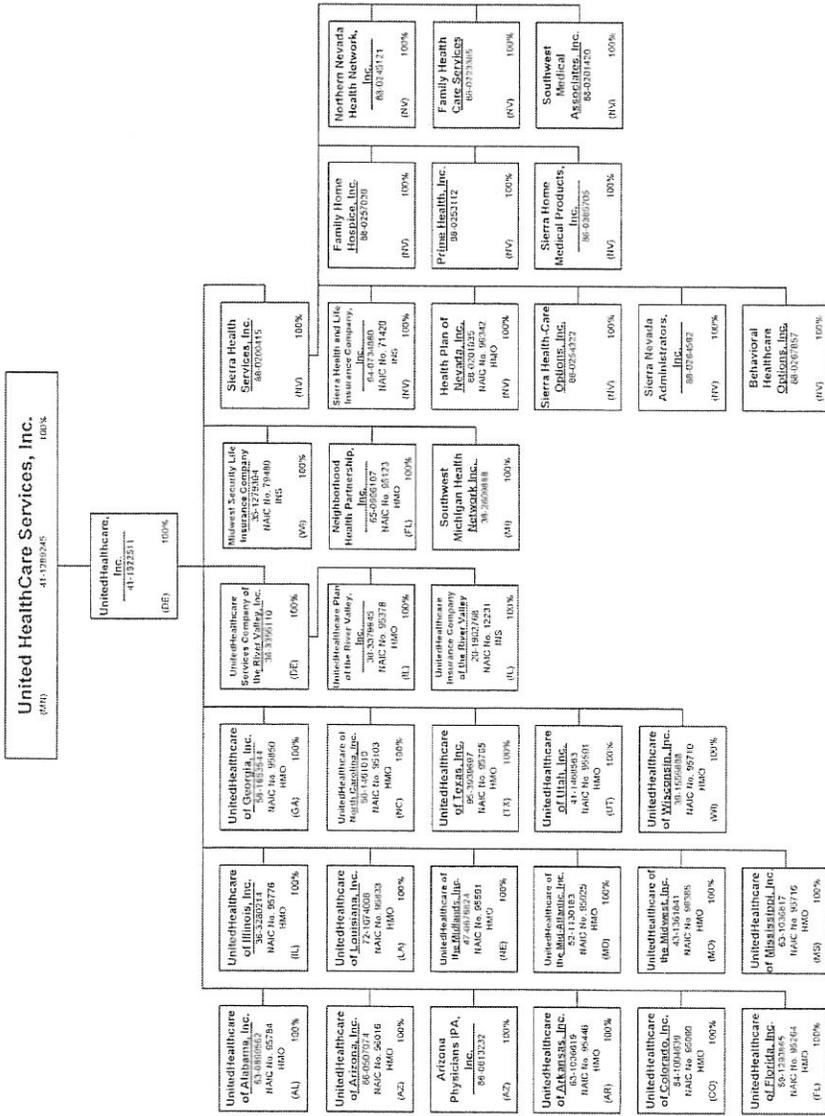
The Company paid the following cash dividends to UnitedHealthcare, Inc., during the period covered by the examination:

<u>Year</u>	<u>Amount</u>
2011	\$ 20,000,000
2012	30,000,000
2013	<u>35,500,000</u>
Total	\$ <u>85,500,000</u>

Organizational Chart

The following chart presents the identities of and interrelationships among all affiliated persons within the UnitedHealth Group Incorporated holding company system at December 31, 2013:





United HealthCare Services, Inc.
 (NASDAQ: UHS)
 41-120240 100%



Notes

- All legal entities on the Organization Chart are Corporations unless otherwise indicated.
- (1) Entity is a Limited Liability Company
 - (2) Entity is a Partnership
 - (3) Entity is a Non-Profit Corporation
 - (4) Control of the Foundation is based on sole membership, not the ownership of voting securities
 - (5) Monarch Financial Services, LLC is 85% owned by Monarch Management Services, Inc. and 15% owned by external shareholders.
 - (6) UnitedHealth Group Information Services Private Limited is 99.37% owned by UnitedHealth Group International B.V.. The remaining 0.63% is owned by UnitedHealth International, Inc.
 - (7) United Healthcare India Private Limited is 99.9935% owned by UnitedHealthcare International B.V. and 0.0065% owned by UnitedHealth International, Inc.
 - (8) General partnership interests are held by United HealthCare Services, Inc. (89.77%) and by UnitedHealthcare, Inc. (10.23%). United HealthCare Services, Inc. also holds 100% of the limited partnership interests. When combining general and limited partner interests, United HealthCare Services, Inc. owns 84.18% and UnitedHealthcare, Inc. owns 5.83%.
 - (9) Branch office located in Abu Dhabi, UAE.
 - (10) WellMed Medical Management, Inc. is 80% owned by Collaborative Care Holdings, LLC and 20% owned by VMG Healthcare Partners, L.P.
 - (11) Physicians Choice Insurance Service, LLC is 70% owned by Monarch Financial Services, LLC and 30% owned by external shareholders.
 - (12) Personal Performance Consultants India Private Limited is 99.998% owned by OptumHealth International B.V. and 0.004% owned by United Behavioral Health.
 - (13) INSPIRIS of Texas Physicians Group is a Texas non-profit (taxable) whose sole member is Inspira Services Company.
 - (14) PrimeCare of Citrus Valley, Inc. is 80% owned by PrimeCare Medical Network, Inc. and 20% owned by Citrus Valley Medical Associates, Inc.
 - (15) OptumInsight Poland sp. z o.o. is 99% owned by Ingenix Innovus (Netherlands) B.V. The remaining 1% is owned by OptumInsight, Inc.
 - (16) GSSI Technologies India Private Limited is 99.9% owned by Quality Software Services, Inc. and 0.1% owned by an Indian citizen.
 - (17) Amico Saúde Ltda. is 99.99% owned by Amíl Participações S.A. and the remaining percent is owned by and officer of Amíl.
 - (18) Ethio - Empresa de Serviços Hospitalares S.A. is 95.52% owned by Amíl Assistência Médica Internacional S.A.; 2.84% owned by Amico Saúde Ltda.; 0.0001% owned by Treasury Shares and 1.62% owned by external shareholders.
 - (19) Ethio - Empresa de Tecnologia Hospitalar Ltda. 50.01% owned by Amíl Assistência Médica Internacional S.A. and 49.99% owned by an external shareholder.
 - (20) Waypoint Holdings is 80% owned by UnitedHealth Group Ventures, LLC and 20% owned by external shareholders.
 - (21) Execillon Serviços Biomédicos S.A. is 99.98% owned by Ethio - Empresa de Serviços Hospitalares S.A. and 0.02% owned by external shareholders.
 - (22) Branch offices in Iraq and Uganda.
 - (23) Central Care Empresa de Alargamentos Clínicos Geral Ltda. is 99.94% owned by Amíl Assistência Médica Internacional S.A.; 2.54% owned by Amico Saúde Ltd. and 0.53% owned by ASL Assistência a Saúde Ltda.
 - (24) Optum 300, LLC is 75% owned by Optum Rocket, Inc. and 25% owned by an external limited holder.
 - (25) Optum Health & Technology Serviços Do Brasil Ltda. is 99% owned by Ingenix Innovus (Netherlands) B.V. and 1% owned by OptumInsight, Inc.
 - (26) Bosque Medical Center S.A. is 65.88% owned by Amíl Assistência Médica Internacional S.A.; 27.89% owned by Amico Saúde Ltd. and 0.64% owned by Ethio - Empresa de Serviços Hospitalares S.A.
 - (27) AHJV, Inc. is 75% owned by NAMM Holdings, Inc. and 25% owned by Humana, Inc.
 - (28) Entity is majority-owned by UHG or one of its affiliates. Corporate secretarial services for this entity are the responsibility of the portfolio company.
 - (29) Premarket Propaganda e Marketing Ltda. is 99.79% owned by Amíl Assistência Médica Internacional S.A. and 0.21% owned by Amico Saúde Ltd.
 - (30) Amíl Clinical Research Participações Ltda. is 99.95% owned by Amíl Lifesciences Participações Ltda. and 0.05% owned by an officer of Amíl.
 - (31) Inmed Star Serviços Médicos e Odontológicos Ltda. is 50% owned by Amíl Assistência Médica Internacional S.A. and 50% owned by Amico Saúde Ltd.
 - (32) Optum Argentina is 90% owned by Ingenix Innovus (Netherlands) BV and 10% owned by ScriptSwitch Holdings Limited.
 - (33) Hospital Alameda Teguastinga Ltda. is 99.99% owned by Amíl Assistência Médica Internacional S.A. and the remaining percent is owned by an officer of Amíl.
 - (34) Amíl Lifesciences Participações Ltda. is 99.998% owned by Amíl Assistência Médica Internacional S.A. and the remaining 0.002% is owned by an officer of Amíl.
 - (35) FrontierMedex Kenya Limited is 99.9% owned by FrontierMEDEX Limited and 0.1% owned by a director of Frontier Medex Kenya Limited.
 - (36) Optum300 Services, Inc. is 75% owned by Optum Rocket, Inc. and 25% owned by an external interest holder.
 - (37) The limited partners of UnitedHealth Group International, L.P. include FMG Holdings, LLC (15.8303%), Hygela Corporation (DE) (0.2008%) and UnitedHealth Group Incorporated (83.9691%). UnitedHealth Group International GP is the general partner of UnitedHealth Group International, L.P..
 - (38) Palar II Fundo de Investimento em Participações is a Brazilian private equity investment fund incorporated in the form of a closed-end condominium.
 - (39) UnitedHealthcare International I, B.V. is 75.78% owned by UnitedHealth Group International L.P. and 24.24% owned by UnitedHealth Group International B.V.
 - (40) Amíl Assistência Médica Internacional S.A. is 90.23% owned by Palar II Fundo de Investimento em Participações and the remaining 9.77% is owned by the former controlling shareholders of Amíl Participações S.A.
 - (41) HPP A.C.E. is 70% owned by HPP - Hospitais Privados do Portugal, SGPS, S.A. The remaining 30% is owned by (1) HPP Douro, S.A.; (2) HPP Lusiadas, S.A.; (3) HPP Alentejo, S.A.; (4) HPP Saúde - Patentes Castela, S.A.; and (5) HPP Viseu, S.A.; each owning 6%.
 - (42) HPP Viseu, S.A. is 65% owned by HPP - Hospitais Privados do Portugal, SGPS, S.A. The remaining 35% is jointly owned by VISABEIRA Saúde - Serviços de Saúde, S.A.; VISABEIRA Participações Financeiras, SGPS, S.A.; VISABEIRA Investimentos Financeiros SGPS, S.A. and Ciborama - Estudos, Projetos e Produções, Lda.
 - (43) Frontier Medox Tanzania Limited is 99% owned by FrontierMEDEX Limited. The remaining 1% is owned by an officer of FrontierMEDEX Limited.
 - (44) Branch office located in Taiwan
 - (45) Ltilson office located in Beijing.
 - (46) Branch office located in Hong Kong
 - (47) Representative office in Beijing

Transactions and Agreements with Affiliates

United HealthCare Services, Inc. - Management Services Agreement

The Management Services Agreement (Agreement) was entered into as of January 1, 2011, by and between the Company and United HealthCare Services, Inc. (UHS). Pursuant to the Agreement, UHS provides management and operational support to the Company including but not limited to those services described in Exhibit A of the Management Services Agreement. The Agreement includes additional services as compared to the previous Amended and Restated Management Agreement, such as disease management, health care decision support and wellness management. The following includes some of the management and operational services described in the Agreement:

UHS Duties: UHS will provide the following management and operational support to the Company:

- Management and General Administration:
 - Banking; Financial analysis and reporting; Human resources; Information technology systems and related activities; Internal audit; Legal, compliance, and regulatory affairs; Real estate, office equipment, and supplies; Tax; and Treasury and investments.
- Operations:
 - Actuarial and underwriting; Benefit design and benefit administration; Call centers and related activities, including, without limitation, enrollee and provider support activities; Claims adjudication and payment systems and related activities; Cost containment; Data clearinghouse and data warehouse systems and related activities; Data management (e.g., maintenance of data, oversight of use and disclosure of data, data accuracy and integrity); Disease management; Financial administration system, including, without limitation, health savings accounts and systems for electronic customer payments and statements; and related activities; Health care decision support; Marketing, sales, and public relations; medical management, including, without limitation, utilization review and utilization management; Pharmacy administration; Provider networks and related activities, including, without limitation, contracting processes and provider relations; Quality oversight; Specialty

benefit management systems and related activities; Third party administration; and wellness management.

Company Control and Oversight: The Company will provide reasonable direction to UHS as it pertains to the services provided by UHS under the terms of the Agreement. In respect to any third party administrator (TPA) services provided by UHS, the parties will comply with the provision as set forth in the Agreement under each of the captions listed below:

1. Advertising
2. Underwriting Standard
3. Premium Collection and Payment of Claims
4. Delivery of Policies and Notices
5. Communication with Claimants
6. Compensation for Adjusting or Settling Claims
7. Bond Required

The Agreement included a Medicare Provisions Addendum. The Medicare Regulatory Requirements Appendix applies to the services performed by UHS pursuant to the Agreement solely as the services relate to Medicare Benefit Plan which is sponsored, issued and administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program with the Prescription Drug program pursuant to Title XVIII, Part C and Part D.

Determination of Management Fees: The Company will pay fees to UHS pursuant to the Agreement equal to:

- a) UHS's expenses for services or use of assets provided solely to the Company, and
- b) the Company's allocated portion of UHS's Expenses where the services or use of assets are shared among the Company and other Health Plans. UHS will determine allocation to the Company each year based on appropriate and rational methods, such as:
 - i. the ratio of the Company's membership to the total membership of the Health Plans sharing such services and assets;
 - ii. the ratio of the Company's utilization of the services or assets to the total utilization by the Health Plans; or
 - iii. the ratio of the Company's revenue to the total revenue of the Health Plans. The parties agree that, with respect to some services and use of assets, calculating the Management Fees pursuant to this section "Determination of Management Fees" will involve management's

reasonable estimate of the Company's Expenses. All management fees will be fair and reasonable and all allocations to the Company will be fair, reasonable, and in conformity with required and customary insurance accounting practice.

Monthly Payments: The Company will pay the "Management Fees" to UHS on or before the 10th calendar day of each month. For management fees that are based on management's reasonable estimate of expenses, the parties agree that, on an annual basis, UHS will review the year-to-date expenses incurred for the ten current calendar years and evaluate whether to adjust the management fees on a prospective basis in order to ensure that the management fees continue to reflect a reasonable estimate of UHS expenses and are fair and reasonable.

The agreement, was filed for review and approval by the Commissioner of the Alabama Department of Insurance (ALDOI) on November 30, 2010, and was approved by ALDOI on January 5, 2011

UnitedHealthcare Insurance Company, Inc. - Premium Allocation Agreement

Effective January 1, 1998, the Company entered into an addendum to a Premium Allocation Agreement dated January 1, 1998, by and between UnitedHealthcare Insurance Company, Inc. ("UHIC") and United HealthCare Services, Inc. This Premium Allocation Agreement (the "Agreement") provides how premiums will be allocated for products marketed jointly by UHIC and the Company. The Agreement was filed with the Department in 2001, but approval was not required as the Company is not a direct contractor under the Agreement.

UnitedHealth Group, Incorporated – First Restated Tax Sharing Agreement

Effective January 1, 1997, the Company entered into the First Restated Tax Sharing Agreement (the "Agreement") with United HealthCare Corporation, which subsequently became UnitedHealth Group, Incorporated, ("UHG"), the ultimate controlling party in the holding company system. The Agreement establishes a formal method for the allocation and payment of federal, state and local income tax liabilities related to the consolidated federal income returns filed each year. The Agreement was filed with the Department on April 2, 2004, and was approved by the Department on May 18, 2004.

UnitedHealth Group Incorporated - Amended and Restated Subordinated Revolving Credit Agreement

Effective September 1, 2012, the Company entered into the Amended and Restated Revolving Credit Agreement (the “Agreement”) with UnitedHealth Group Incorporated (UHG). Under the terms of the Agreement, UHG is providing a short-term borrowing facility for the Company which shall be repaid within one year of the date on which the loan was initially made. The Company is able to borrow upon demand from UHG up to a maximum amount of \$35,000,000 outstanding at any time. The Agreement was submitted to the Department for review and approval on July 13, 2012, and was approved by the Department on August 8, 2012.

Combined Billing and Disbursement Operations Agreement

Effective June 1, 2010, the Company, United HealthCare Services, Inc. (“UHS”) and UnitedHealthcare Insurance Company (“UHIC”) entered in an agreement for the combined billing and disbursement operations (the “Agreement”). UHS consolidated its computer platforms in order to bring greater efficiency in the delivery of products and services from its affiliates. Since many customers purchase products or services from more than one affiliate, but expect administrative ease, one aspect in the change of the computer platform provided a customer with a combined bill and directs a single payment to a common bank lockbox held in the name of UHIC. Under this pre-settlement lockbox arrangement, all incoming receipts are identified and sorted according to proper affiliate company, and promptly transferred to the appropriate health plan or insurance company owned account. This clearance process lasts no more than a few days with transfers occurring five (5) times per month. This pre-settlement process is a short-term arrangement, which will ease administrative complexity for the Company’s customers. It neither involves nor contemplates pooling of assets for investment or investment-related purposes. The Agreement was submitted to the Department for review and approval on April 7, 2010, and was approved by the Department on September 14, 2010.

Dental Benefit Providers, Inc. – Dental Services Agreement

IIPAS #5936-A

Effective February 1, 2012, the Company entered into the Dental Services Agreement (the “Agreement”) with Dental Benefit Providers, Inc. (“DBP”). Pursuant to the Agreement, DBP is responsible for managing a network of dental providers, claims processing and other administrative functions in order to provide dental services for the Company’s Medicare members. The Company remains ultimately responsible for

the delivery of dental health care to its members. The Agreement was submitted to the Department for informational purpose on December 9, 2011.

IIPAS #5936-B

Effective June 1, 2013, the Company entered into the First Amendment to the Agreement (the “First Amendment”). The First Amendment deleted and replaced Exhibit A “Compensation for Services Addendum” in its entirety. The First Amendment was submitted to the Department for informational purpose only on April 5, 2013.

IIPAS #5936-A-B

Effective January 1, 2014, the Agreement and the First Amendment were replaced and superseded by the Dental Services Agreement (IIPAS #6383-A).

IIPAS #6383-A

Effective January 1, 2014, the Company entered into the Dental Services Agreement (the “Agreement”) with Dental Benefit Providers, Inc. (“DBP”). Pursuant to the Agreement, DBP is responsible for managing a network of dental providers, claims processing and other administrative functions in order to provide dental services for the Company’s Commercial and Medicare members. The Company remains ultimately responsible for the delivery of dental health care to its members. The Agreement was submitted to the Department for review and approval on November 8, 2013, and was approved by the Department on November 22, 2013.

OptumHealth Care Solutions, Inc. – Administrative Services Agreement

IIPAS #6128-A

Effective April 1, 2012, the Company entered into the Administrative Services (the “Agreement”) with OptumHealth Care Solutions, Inc. (“OptumHealth”). Pursuant to the Agreement, OptumHealth is responsible for managing a network of therapy providers and other administrative functions in order to provide physical health solutions such as chiropractic and physical, occupation and speech therapy for the Company’s Commercial and Medicare members. The Company remains ultimately responsible for the delivery of therapy services to its members. The Agreement was submitted to the Department for review and approval on February 14, 2012, and was approved by the Department on March 8, 2012.

IIPAS #6128-B

Effective March 1, 2013, the Company entered into the First Amendment to the Agreement (the “First Amendment”). The First Amendment amended the Agreement by deleting and replacing Exhibit A Compensation for Services

Addendum and Exhibit C Medicare Advantage Regulatory Requirements Appendix. The First Amendment was submitted to the Department for review and approval on January 14, 2013, and was approved by the Department on January, 25, 2013.

Evercare Hospice, Inc. – Facility Participation Agreement

IIPAS #6159-A

Effective January 1, 2013, the Company entered into the Facility Participation Agreement (the “Agreement”) with Evercare Hospice, Inc. (“EVC Hospice”). Under the terms of the Agreement, EVC Hospice is a provider of Hospice Services for the Company’s Commercial members. The Agreement was submitted to the Department for review and approval on November 20, 2012, and was approved by the Department under on December 10, 2012.

OptumInsight, Inc. f/k/a Ingenix, Inc. – OptumInsight Services Agreement

IIPAS #5668-A

Effective July 1, 2011 the Company entered into the Ingenix Services Agreement (the “Agreement”) with Ingenix, Inc. (“Ingenix”). Pursuant to the Agreement, Ingenix provides services related to claim analytics and recovery services, retrospective fraud, waste and abuse services and subrogation services. The Agreement replaced the Retrospective Fraud and Abuse Services Agreement effective February 1, 2009 and the Subrogation Agreement effective January 1, 2009. The Agreement was submitted for review and approval to the Department on May 31, 2011, and was approved by the Department on June 17, 2011.

IIPAS #5668-B

Effective July 1, 2012, the Company entered into the First Amendment to the Agreement. The Amendment modified the Agreement to be known now as the OptumInsight Services Agreement and changed the address for all notices and official communication. In addition Exhibit A-1, A-2 and A-3, to the extent applicable, were amended by the pricing terms. The First Amendment was submitted to the Department for review and approval on May 3, 2012 and was approved by the Department on May, 23, 2012.

IIPAS #5668-C

Effective September 1, 2013, the Company entered into the Second Amendment to the Agreement (the “Second Amendment”). The Second Amendment amended applicable compensation sections in Exhibit A-1 and/or A-2 and/or A-3 and amended the description of ‘Legal Action’ in Exhibit A-1 and Exhibit A-2. The

Second Amendment was submitted to the Department on July 9, 2013, and was approved by the Department on July 19, 2013.

IIPAS #5668-D

Effective May 1, 2014, the Company entered into the Third Amendment to the Agreement (the "Third Amendment"). The Third Amendment eliminated and replaced Exhibits A-1 and or A-2 and or A-3 to the original Agreement and added Exhibit A-4 to the Agreement. The Third Amendment was submitted to the Department for review and approval on March 18, 2014, and was accepted by the Department on April 9, 2014.

OptumRx, Inc. (f/ka/ RxSolutions, Inc.) - Health Supplies Agreement for Medicare/Medicaid Members

IIPAS # 5598-A-B

Effective February 25, 2009, the Company entered into a Health Supplies Agreement (the "Agreement") between United HealthCare Products, LLC ("UHC - Products"), a Delaware limited liability company, and United HealthCare Services, Inc. ("UHS") by way of the First Amendment to the Agreement. The Company and other affiliates began taking advantage of the services offered under this Agreement during the course of the 2008 calendar year. The Agreement is applicable to Medicare Advantage and dual eligible Medicare-Medicaid business. Under the terms of the Agreement, UHC - Products provides catalogues to the Company's members. These members receive points for each quarter they are insured by the Company. The points accumulate for individual plan years only. The points can be used to "purchase" items from the catalogue or items may also be purchased outright. Items include over-the-counter drugs, canes, and other durable medical equipment. The Company pays a base amount which increases depending on the amount purchased. The Agreement and the First Amendment to the Agreement were provided to the Department for information only on January 23, 2009.

IPASS # 5598-C and #5598-D

Effective January 1, 2011, the Company entered into a Second and Third Amendment to the Agreement. The Second and Third Amendment to the Agreement were provided to the Department for information only on December 23, 2010.

IIPAS #5598-E

Effective February 1, 2012, the Company entered into Amendment IV to the Agreement by way of a Participating Addendum. Amendment III only amended Exhibit D, Legal Entities which continued to include the Company and Amendment IV also only amended Exhibit D, Legal Entities which continues to include the

Company and reflects the name change from RxSolutions, Inc. to OptumRx, Inc. Amendment IV was provided to the Department for information only on December 9, 2011.

IIPAS #5598-F

Effective January 1, 2013, the Company entered into Amendment V to the Agreement (the “Amendment V”) by way of a Participating Addendum. Amendment V deleted and replaced Exhibit B Compensation, added Exhibit B-1 Compensation for Monthly Credit Expiration Plans, deleted and replaced Exhibit D Legal Entities and modified the Agreement by adding the “2013 Health Products Benefit Product Assortment” as Appendix 1 as set forth in Attachment IV. The Amendment V was filed with the Department for review and approval on November 19, 2012 and was approved by the Department on December 10, 2012.

IIPAS #5598-G

Effective January 1, 2014, the Company entered into Amendment VI to the Agreement (the “Amendment VI”) by way of a Participating Addendum. Amendment VI deleted and replaced Section 3.2, Year-End Reconciliation, Exhibit B, Compensation, deleted B-1 Compensation for Monthly Credit Expiration, deleted and replaced Exhibit D, Legal Entities and deleted Appendix 1 “2013 Health Products Benefit Product Assortment”. The Amendment VI was filed with the Department for review and approval on September 30, 2013 and was approved on October 28, 2013.

OptumRx, Inc. - Medicare Prescription Drug Benefit Administration Agreement

IIPAS #6262-A

Effective January 1, 2013, OptumRx, Inc. (“OptumRx”) and United HealthCare Services, Inc. (“UHS”) entered into the Medicare Prescription Drug Benefit Administration Agreement (the “Agreement”). The Company was added to the Agreement as a participant through signing a Participating Addendum effective January 1, 2013. Under the terms of the Agreement, OptumRx is the Pharmacy Benefit Manager for the Company’s MA-PD and PDP plans. The Agreement was filed with the Department for information only on November 29, 2012.

IIPAS #6262-B

Effective January 1, 2013, OptumRx and UHS entered into the First Amendment to Agreement (the “First Amendment”). The Company was added to the First Amendment as a participant through signing a Participating Addendum effective July 1, 2013. The First Amendment modified the Agreement by amended Section 4.4 and deleting and replacing Exhibit B of the Agreement in its entirety. The changes in the

First Amendment were based on direction provided by CMS through the annual bid process and at the request of CMS. The First Amendment was filed with the Department for information only on June 24, 2013.

IIPAS #6262-C

Effective January 1, 2013, OptumRx and UHS entered into the Second Amendment to the Agreement (“Second Amendment”). The Second Amendment effective January 1, 2013, clarified the legal entities that are participating in the Agreement effective as of January 1, 2013.

IIPAS #6262-D

Effective January 1, 2014, OptumRx and UHS entered into the Third Amendment to the Agreement (the “Third Amendment”). The Third Amendment effective January 1, 2014, modified the Agreement by deleting and replacing Exhibit B, inserting a new Section 1.7 to Exhibit C and deleting and replacing Exhibit C-1.

IIPAS #6262-A-D PBM MO AM01

Effective January 1, 2014, OptumRx and UHS entered into the First Amendment to the Prescription Drug Benefit Mail Order Network Agreement (the “Amendment to the Mail Order Network”). The Amendment to the Mail Order Network effective January 1, 2014, modified the Exhibit E to the Prescription Drug Benefit Mail Order Network Agreement by deleting and replacing Exhibit B and Exhibit C.

Effective January 1, 2014, the Company participates in the Second Amendment, Third Amendment and First Amendment to the Mail Order by signing a Participating Addendum. The Second Amendment, Third Amendment and First Amendment to the Mail Order and the Participating Addendum were filed with the Department for information only on November 18, 2013.

OptumRx, Inc. f/k/a/ RxSolutions, Inc. - Medicare Advantage Durable Medical Equipment and Supplies Mail Order Network Agreement

IIPAS #5600-A

Effective January 1, 2009, the Company became a party to the Medicare Advantage Durable Medical Equipment and Supplies Mail Order Network Agreement between RxSolutions, Inc. doing business as Prescription Solutions® (“RxSolutions”) and United HealthCare Services, Inc. on behalf of itself and its affiliates including the Company (collectively referred to as “United”) (the “Agreement”). Pursuant to the Agreement, RxSolutions provides durable medical equipment and supplies to Medicare Advantage members in connection with United’s Medicare Advantage

operations. The Agreement was provided to the Department for information only on January 22, 2009.

Spectera, Inc. – Vision Services Agreement

IIPAS #5976-A

Effective January 1, 2012, the Company entered into the Vision Services Agreement (the “Agreement”) with Spectera, Inc. (“Spectera”). Pursuant to the Agreement Spectera is responsible for managing a network of vision providers to provide vision services and or products (frames and contact lenses), claims processing and other administrative functions in order to provide vision services to the Company’s Commercial and Medicare members. The Agreement was submitted to the Department for review and approval on November 21, 2011 and was approved by the Department on December 21, 2011.

IIPAS #5976-B

Effective May 1, 2013, the Company entered into the First Amendment to the Agreement (the “First Amendment”). The First Amendment deleted and replaced Exhibit A “Compensation for Services Addendum” in its entirety. The First Amendment was submitted to the Department for review and approval on March 22, 2013, and was approved by the Department on April 9, 2013.

IIPAS #5976-C

Effective January 1, 2014, the Company entered into the Second Amendment to the Agreement (the “Second Amendment”). The Second Amendment deleted and replaced Exhibit A, “Compensation for Services Addendum” and deleted Exhibit C, “Medicare Advantage Regulatory Requirements Appendix” and Exhibit E, “State Regulatory Requirements Appendix”. The Second Amendment was submitted to the Department for review and approval on November 4, 2013 and was approved by the Department on November 18, 2013.

IIPAS #5976-D

Effective April 1, 2014, the Company entered into the Third Amendment to the Agreement (the “Third Amendment”). The Third Amendment added Specialty Benefits, LLC to the Agreement and deleted and replaced Exhibit A “Compensation for Services Addendum” and Exhibit B “Services Addendum”. The Third Amendment was submitted for review and approval to the Department on February 24, 2014, and was approved by the Department on March 17, 2014.

United Behavioral Health – Behavioral Health Services Agreement

IIPAS #6080-A

Effective March 1, 2012, the Company entered into the Behavioral Health Services Agreement (the “Agreement”) with United Behavioral Health (“UBH”). Pursuant to the Agreement, UBH is responsible for arranging for the provision of certain mental health and substance abuse treatment services to the Company’s Commercial and Medicare members. The Agreement was submitted to the Department for review and approval on January 23, 2012, and was approved by the Department on March 19, 2012.

IIPAS #6080-B

Effective March 1, 2013, the Company entered into the Amendment No. 1 to the Agreement (the “Amendment One”). Amendment One deleted and replaced the rate chart in Section 1 of Exhibit A in its entirety. The Amendment One was submitted to the Department for review and approval on January 15, 2013, and was approved by the Department on January 29, 2013.

IIPAS #6080-C

Effective January 1, 2014, the Company entered into the Amendment No. 2 to the Agreement (the “Amendment Two”). Amendment 2 deleted and replaced the rate chart in Section 1 of Exhibit A in its entirety and Exhibit C, “Medicare Advantage Regulatory Requirement Appendix. The Amendment 2 was submitted to the Department for review and approval on November 7, 2013, and was approved by the Department on November 22, 2013.

Optum Biometrics f/ k/ a Wellness, Inc. - Facility Provider Agreement

IIPA #1226-A

Effective October 1, 2010, the Company began participating in the Facility Participation Agreement (the “Agreement”) by and between Wellness, Inc. (“Wellness”) and UnitedHealthcare Insurance Company (“UHIC”). The purpose of the Agreement is to provide influenza and pneumococcal vaccination services to the company’s Commercial and Medicare members. The fees are charged per vaccination given and are the same for all Wellness customers. The Agreement was submitted to the Department for review and approval on August 19, 2010 and was approved by the Department on September 13, 2010.

Insolvency Reinsurance Agreement (IOA-002)

Effective January 1, 2005, the Company entered into the Insolvency Reinsurance Agreement (the "Agreement") with UnitedHealthcare Insurance Company, Inc. The Agreement provides coverage only in the case of the Company's insolvency. The Agreement was submitted to the Department on November 3, 2004, for review and approval on August 19, 2010, and was approved by the Department on September 13, 2010.

OptumRx, Inc. – Facility Participation Agreement

IIPAS# 6045-A

Effective January 1, 2012, the Company entered into the Facility Participation Agreement (the "Agreement") with OptumRx, Inc. ("OptumRx"). Under the terms of the Agreement, OptumRx is a provider of Durable Medical Equipment Services and Hearing Aids for the Company's members. The Agreement is available to be used by all products, Commercial, Medicare and Medicaid that the Company may offer. The Agreement was submitted to the Department for review and approval on November 11, 2011, and was approved by the Department on December 13, 2011.

IIPAS #6045-B

Effective January 1, 2013, the Company entered into an Amendment One to the Facility Participation Agreement (the "Amendment One"). Amendment One updated the rates to add additional hearing aids and deleted the durable medical equipment fee schedule that was attached to the Facility Participation Agreement as they are no longer being utilized. OptumRx continues to provide hearing aids to the Company's Commercial and Medicare members. The Amendment One was submitted to the Department for review and approval on November 14, 2012 and was approved by the Department on December 13, 2012.

IIPAS #6045-C

Effective January 1, 2014, the Company entered into an Amendment Two to the Agreement (the "Amendment Two"). The Amendment Two modified the Agreement and the Amendment One by deleting and replacing Appendix 3A-2 "DME/Hearing Aid Services Fee Schedule" in its entirety. The Amendment Two was submitted to the Department for review and approval on August 6, 2013 and was approved by the Department on August 16, 2013.

OptumRx, Inc. f/k/a RxSolutions, Inc. - Facility Participation Agreement - for Specialty Pharmacy Provider Agreement, Medical Benefit

IIPAS #5601-A

Effective May 1, 2008, the Company is participating in the Facility Participation Agreement for Specialty Pharmacy Provider Agreement – Medical Benefit (the “Agreement”) between UnitedHealthcare Insurance Company (“UHIC”), on behalf of itself and its affiliates, including the Company, and RxSolutions, Inc. (“RxSolutions”) The Agreement is for pharmacy medications covered under the UHCAL pharmacy benefits. The purpose of the Agreement is to enable RxSolutions to act as a specialty pharmacy provider. The Agreement is helping the Company to manage the cost of specialty medications. The Agreement is applicable only to the Company’s Commercial business and not to any government program business. The Agreement was submitted to the Department for review and approval on March 20, 2008, and was approved by the Department on April 2, 2008.

IIPAS #5601-B

On August 1, 2009, UHIC and RxSolutions entered into a First Amendment to the Facility Participation Agreement (“First Amendment”) to allow Medicaid members to participate. While the First Amendment is not applicable to the Company, since there are no Medicaid members, the First Amendment was provided to the Department for information to explain the numbering of the Amendments.

IIPAS #5601-C

On August 1, 2011, UHIC and RxSolutions entered into a Second Amendment to the Facility Participation Agreement (“Second Amendment”). The Second Amendment amended Appendix 3, Exhibit A, Specialty Pharmacy Medications Payment Appendix, Appendix 1, Facility Locations and Service Listings and Appendix 7, Medicare Advantage Regulatory Requirements Appendix. All other provisions of the Agreement remained in full force and effect.

Effective October 1, 2011, the Company participated in the Second Amendment through signing a Participating Addendum. The First Amendment, the Second Amendment and the Participating Addendum were filed with the Department for review and approval on August 30, 2011, and the Second Amendment and the Participating Addendum were approved by the Department on September 15, 2011.

IIPAS #5601-D

On February 1, 2014, UHIC and OptumRx entered into a Third Amendment to the Facility Participation Agreement (the “Third Amendment”). The Third Amendment amended the list of Attachments at the signature portion of the Agreement to include

Medicare-Medicaid Regulatory Requirements, amended Appendix 2: Benefit Plan Descriptions, deleted Appendix 3: Exhibit A, "Specialty Pharmacy Medications Payment Appendix" and replaced it with the Appendix 3: Exhibit A, "Payment Appendix, Specialty Pharmacy Services, Medical Benefit", deleted Exhibit B, "Parameters and Requirements for Specialty Pharmacy Network Participation" and replaced it with Exhibit B, "Specialty Pharmacy Network Requirements, Standards and Guarantees" and Appendix 7, "Medicare Advantage Regulatory Requirements Appendix" was deleted and replaced.

Effective May 1, 2014, the Company participates in the Third Amendment through signing a Participating Addendum. The Third Amendment and the Participating Addendum were submitted for review and approval to the Department on March 14, 2014, and were approved by the Department on April 9, 2014.

OptumRx, Inc. (f/k/a RxSolutions, Inc.) - Facility Participation Agreement - for Specialty Pharmacy Provider Agreement, Pharmacy Benefit

IIPAS #5602-A

Effective May 1, 2008, the Company is participating in the Facility Participation Agreement for Specialty Pharmacy Provider Agreement - Pharmacy Benefit (the "Agreement") between United HealthCare Insurance Company, on behalf of itself and its affiliates, including the Company, and RxSolutions, Inc. ("RxSolutions"). The Agreement is for pharmacy medications covered under the Company's pharmacy benefits. The purpose of the Agreement is to enable RxSolutions to act as a specialty pharmacy provider. This agreement will help the Company manage the cost of specialty medications. The Agreement is applicable only to the Company's Commercial business and not to any government program business. The Agreement was submitted to the Department for review and approval on March 20, 2008, and was approved by the Department on April 2, 2008.

IIPAS #5602-B

On August 1, 2009, UHIC and RxSolutions entered into a First Amendment to the Facility Participation Agreement ("First Amendment") to allow Medicaid members to participate. While the First Amendment is not applicable to the Company, since there are no Medicaid members, the First Amendment was provided to the Department for information to explain the numbering of the Amendments.

IIPAS #5602-C

On August 1, 2011, UHIC and RxSolutions entered into a Second Amendment to the Facility Participation Agreement ("Second Amendment"). The Second Amendment amended Exhibit A, Specialty Pharmacy Medications Payment Appendix and

Appendix 1, Facility Locations and Service Listings. All other provisions of the Agreement remained in full force and effect.

Effective October 1, 2011, the Company participated in the Second Amendment through signing a Participating Addendum. The First Amendment, the Second Amendment and the Participating Addendum were submitted for review and approval to the Department for review and approval on August 30, 2011, and were approved by the Department on November 15, 2012. The correction to the effective date from August 1, 2011 to October 1, 2011 was filed on November 3, 2011.

IIPAS #5602-D

On February 1, 2014, UHIC and OptumRx entered into a Third Amendment to the Facility Participation Agreement (the "Third Amendment"). The Third Amendment deleted Exhibit A, "Specialty Pharmacy Medications Payment Appendix, Pharmacy Benefit" and replaced it with Exhibit A, "Payment Appendix, Specialty Pharmacy Services, Pharmacy Benefit" and deleted Exhibit B, "Parameters and Requirements for Specialty Pharmacy Network Participation" and replaced it with Exhibit B, "Specialty Pharmacy Network Requirements, Standards and Guarantees".

Effective May 1, 2014, the Company participates in the Third Amendment through signing a Participating Addendum. The Third Amendment and the Participating Addendum were submitted for review and approval to the Department on March 14, 2014, and were accepted by the Department on April 11, 2014.

OptumRx, Inc. – Prescription Drug Benefit Administration Agreement for Commercial Members

IIPAS #6183-AA

Effective January 1, 2013, OptumRx, Inc. ("OptumRx") and UnitedHealth Care Services, Inc. entered into the Prescription Drug Benefit Administration Agreement (the "Agreement"). The Company was added to the Agreement as a participant through signing a Participating Addendum effective January 1, 2013. This Agreement covers the Company's commercial members only.

Under the terms of the Agreement, OptumRx is providing the company with Core Prescription Drug Benefit Services and Mail Order Pharmacy Services. Under the Core Prescription Drug Benefit Services, OptumRx established and maintain a network of pharmacies to service the benefit plans, provide claims processing services, benefits administration and support, marketing and sales support, account management services, rebate administration, clinical services and finance and analytical support services. Under the Mail Order Pharmacy Services, OptumRx provides the Company with mail order network prescription services. The Company

remains ultimately responsible for the pharmacy benefit administration services provided to its members. The Agreement was submitted to the Department for review and approval on September 21, 2012 and was approved by the Department on October 9, 2012.

FIDELITY BOND AND OTHER INSURANCE

The Company was a named insured on a blanket crime policy issued by National Union Fire Insurance Company of Pittsburgh, Pennsylvania, to UnitedHealth Group Incorporated (UHG). It was determined that UHG maintained an appropriate level of fidelity insurance.

The fidelity bond policy included the following coverages: 1) Employee dishonesty, 2) Loss inside the premises, 3) Loss outside the premises, 4) Money orders and counterfeit paper currency, 5) Depositors' forgery coverage, 6) Credit Card Forgery, 7) Computer Fraud, and 8) Fraud Transfer Fraud.

The Company is also a named insured on a number of insurance policies protecting the Company against hazards to which it may be exposed.

PENSION, STOCK OWNERSHIP AND INSURANCE PLANS

The Company has no employees of its own; therefore, it has no employees' or producer benefits programs. The Company's operations were conducted by the personnel of United HealthCare Services, Inc., (UHS) a Minnesota Corporation under the terms of a Management Services Agreement. The Company's elected officers were also employees of UHS. The Company uses both captive and independent producers in Alabama. The captive producers are employees of UHS. For further comment, see the caption Management Services Agreement – Page 17 under the heading Transactions and Agreements with Affiliates.

Section 1033 of Title 18 of the U.S. CODE

(ALA. ADMIN. CODE 482-1-146-.11(2009))

The Company's business and affairs were managed by the employees of United HealthCare Services, Inc. (UHS). The Company was asked how it complied with ALA. ADMIN. CODE 482-1-146-.11(2009).

Company management indicated that according to UHS's Hiring and Employment Policy and Practices, UHS conducts pre-employment screenings on all individuals

who are given conditional offers of employment, including individuals hired by third-parties who are assigned to work at UHS. In addition to performing pre-employment background checks, UHS conducts post hire criminal background checks on all employees at least once during each calendar year.

The Company was in compliance with ALA. ADMIN. CODE 482-1-146-.11(2009) and Section § 1033 of Title 18 of the U.S. CODE.

SPECIAL DEPOSITS

In order to comply with the statutory requirements, the Company had the following security on deposit with the ALDOI at December 31, 2013:

Description	Par Value	Book/ Adjusted Value	Fair Value
US Treasury Note	\$ <u>100,000</u>	\$ <u>104,916</u>	\$ <u>105,336</u>
Total	\$ <u>100,000</u>	\$ <u>104,916</u>	\$ <u>105,336</u>

MARKET CONDUCT ACTIVITIES

The Company is organized as a Health Maintenance Organization (HMO) and is regulated by the Alabama Department of Public Health (ADPH). During the period covered by the examination, ADPH did not conduct a claims audit on the Company.

Territory

As of December 31, 2013, the Company was licensed to transact business in the state of Alabama. The Certificate of Authority was inspected for the period under review and found to be in order. According to the 2013 Annual Statement the Company was licensed to sell its commercial products in 63 counties.

Plan of Operation

The Company has been in both the large and small group commercial markets since 1986. The Company also serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage (Medicare Part D program) under a contract with Centers for Medicare and Medicaid Services (CMS). Under the Medicare Part D program, there are seven separate elements of payment received by

the Company during the plan year; these payment elements are CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share, and the CMS Coverage Gap Discount Program.

According to the 2013 Annual Statement, the Company offered a variety of managed care programs and products through contractual arrangements with health care providers. The delivery of all professional services was rendered by providers that were under contract with the Company and indirectly through administrative service providers. Members were generally required to use these providers in order for the Company to pay the full benefit for claims submitted by the providers. However, the Company also paid out-of-plan provider claims under certain circumstances, such as emergency care and for health care services from physicians and other providers outside the Company's network under the point-of-service options.

During the exam period, the Company used a combination of internal and external producers to sell its Medicare Advantage & Prescription Drug (MAPD) products. The Company held contracts with external agents as well as external vendor entities that in turn employed or contracted with individual agents to solicit Company products. The Company also employed internal agents who solicited its products. Company products were sold and members were enrolled via telesales, direct/field sales and web based enrollments. The Company indicated the total number of producers employed or licensed (telesales and independent) at December 31, 2013 was 3,407. Producer compensation for MAPD products varies (commissions, incentive pay or consulting fees) based on the type of producer (direct/field sales, employed telesales or vendor telesales). For commercial business the number of producers used by the Company as of December 31, 2013 (telesales and independent) was 1172.

Policy Forms, Rates and Underwriting Practices

At December 31, 2013, the Company was issuing Commercial Health and Medicare policies. The Company filed policy forms and rate increases during the examination period which were approved by the Alabama Department of Insurance.

A review of a sample of item taken from the commercial business premiums listing indicated that for large groups the Company utilized a combination of manual rates developed on rate filings and group level experience.

Advertising and Marketing

The examiners reviewed the advertising and marketing materials used by the Company to promote the commercial business during the period under examination. The marketing of the Company's products was accomplished through the use of business journal, newspaper, billboard advertisements and direct mailing. The Company also uses broad consumer advertising mediums, such as print, radio, TV ads, and websites. This advertising rarely includes specific product information, and did not include specific local references to any UnitedHealthcare plan. Out of a sample of 71 advertisements 34, advertisements included the name of the Company, but the Alabama address of the Company was not included. The Company did not comply with the ALA. ADMIN CODE 482-1-079-.06(1987), which states:

All advertisements must contain the name and address of the HMO as filed with the Commissioner.

Company management indicated that UnitedHealthcare follows a process where legal, regulatory, compliance and brand reviews all advertisement materials prior to production. The documents supporting the review performed by legal, compliance and brand were requested for review by the examiners. The Company maintained the records for 13 items which were reviewed by the examiners.

Claims Payment Practices

Paid Claims

A sample of 109 paid claims from a population of 50,064 paid claims during the period under examination was reviewed for compliance with Alabama Laws and Regulations and compliance with policy provisions, timeliness of payment and adequacy of documentation.

The Company did not provide claims documents or electronic version of the claims documents for six prescription drug payments made by the Company during 2011 and 2012. The Company did not comply with ALA. CODE § 27-21A-16 (f) (1975), which states:

All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner.

The examiners also determined that three claims were not paid within 45 days from the receipt of proof of the fact and amount of loss sustained under the contracts. The Company did not comply with ALA. ADMIN. CODE 482-1-079-.18 (1987), which states:

All licensed HMO's shall consider claims made under their health care contracts and, if found to be valid and proper, shall pay such claims within forty-five (45) days after the receipt of proof of the fact and amount of loss sustained under such contracts.

Claims Denied and Closed Without Payment

A sample of 109 paid claims from a population of 17,584 claims denied and closed without payment during the period under examination was reviewed for compliance with Alabama Laws and Regulations and compliance with policy provisions, timeliness of payment and adequacy of documentation.

The Company did not provide the original documents or electronic version of the claims documents for 10 prescription drug claims closed without payment by the Company. The Company did not comply with ALA. CODE § 27-21A-16 (f) (1975), which states:

(f) All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner.

Policyholder Complaints

The Company's complaint handling policy and procedures addresses all formal complaints including those filed with the Department of Insurance. The complaint log provided by the Company included formal complaints submitted by members enrolled under the commercial business. During the period under examination, there were seven complaints listed on the complaint log, which were reviewed to ensure that the Company maintained adequate documentation.

The review of the documentation indicated that the Company addressed the issues raised by the members in a timely manner. The content of the resolution letter to the members included the reason(s) for the appeal decision along with the reference to specific benefit provisions. The letter also included a notification that the members could obtain upon request, free of charge, a copy of the actual benefit provision and included information about their rights along with the telephone number and address.

Compliance with Producers' Licensing Requirements

A sample of 105 items was selected from a population of 9,790 commercial and Medicare policies written by the producers /agencies on or after May 1, 2012. The examiner utilized the NAIC State Based System (SBS) to verify if the producers in the sample were appropriately appointed at the time of sale /enrollment of the policies. The examiners identified the following eight producers who were not appointed by the Company at the time of sale /enrollment of the policies.

No.	Agent's Code	Policies sold	Policy Number	Premium Amount	Commission Paid
1	138827	1	06P7322	\$ 1,452	\$ 0
2	215377	1	09P1063	0	0
3	*	1	09P5365	16,865	0
4	207524	5	Various#	44,176	0
5	*	1	04S3086	8,122	0
6	2015379*	1	979695481	0	0
7	2060158*	1	908629264	0	0
8	2053616	1	955703173	<u>0</u>	<u>0</u>
Total				\$ <u>70,615</u>	\$ <u>0</u>

*Company management confirmed that the producer /agency were not licensed.
#Policies 09P8150, 08R9646, 08R9649, 08R9655, 09R8680.

In the above chart, the first five producers were from the commercial business producers listing and the last three were from the Medicare business producers listing. The amounts listed in the "Premium Amount and Commissions Paid" columns were provided by the Company. The "Premium Amount" column represents premiums received by the Company from the effective date of the policy to the date when the producers were appointed for the Company. The "Commissions Paid" column indicates zero in commission payments as no commissions were paid to the producers.

The examiners recalculated the premium amount for each of the five producers listed in the above chart. The examiners inquired if commission payments to the producers were deferred until such time when the producers were appointed. The Company provided the following response:

A producer would receive commissions' retro to the date the business was placed only if he was appointed within the 15 day window allowed by AL law. Otherwise, the payment date of commissions depends on

the revenue date United's billing department sends to the commission unit. The commission unit would begin paying commissions the first revenue date after his appointment. Typically, that would be the following full month.

For example, if a group's coverage is effective 04/01/15 and the producer is appointed by April 15th he would receive a commission for April. If the producer was appointed outside the 15 day window, e.g. June 15th, United would not begin paying commissions until July and it would not include amounts for the months of April, May and June

The response indicated that producers would not receive commissions for the period they were not appointed for the Company, except if a producer was appointed in accordance with ALA. ADMIN. CODE 482-1-147-.10 (2013), which states:

(3) The notice of appointment shall be completed by the insurer within 15 days from the date the agency contract is executed or the first insurance application is submitted, whichever occurs first.

The examiners did not verify the accuracy of commissions paid to the five producers from the commercial business listing appointed after the applications were first submitted to the Company.

Since the producers/agencies listed above were not licensed /appointed at the time of sale/enrollment of the policy, the Company was not in compliance with ALA. CODE § 27-7-4 (1975), which states:

(a) No person shall in this state sell, solicit, or negotiate insurance for any class or classes of insurance unless the person is then licensed for that line of authority in accordance with this chapter. Any insurer accepting business directly from a person not licensed for that line of authority and not appointed by the insurer shall be liable to a fine up to three times the premium received from the person.

The amounts in the premium column were calculated as follows:

Producer 1 (commercial):

The group application for policy number 06P7322 was received on July 11, 2012, with an effective date of August 1, 2012. The producer was appointed on October 15, 2012, which was after the effective date of the

policy. The \$1,452 in premiums was determined to be for the period prior to the appointment of the producer and included premiums for August and September along with 15 days premiums for the month of October. The producers received commissions for the first time on the policy on December 17, 2012.

Producer 2 (commercial):

The group application for policy number 09P1063 was received on December 10, 2012, with an effective date of January 1, 2013. The producer was appointed on December 18, 2012. Company management indicated that the producer was appointed prior to receiving any premiums from the group. Company management also indicated that they had complied with ALA. ADMIN. CODE 482-1-147-.10(3)(2013), which required that the insurers complete the appointment within 15 days after the first application is submitted. ALA. ADMIN. CODE 482-1-147-.10(3)(2013), which was effective January 1, 2013, states:

(3) The notice of appointment shall be completed by the insurer within 15 days from the date the agency contract is executed or the first insurance application is submitted, whichever occurs first.

Company management indicated that no premiums were received prior to the appointment of the producer. The producer received commissions on April 2, 2013 for the period January to March.

Producer 3 (commercial):

The group application for policy # 09P5365 was received on December 13, 2012, with an effective date of January 15, 2013. Company management indicated the following:

- The agency was not licensed in Alabama and was not appointed for the Company.
- The writing producer was licensed in Alabama on March 7, 2007 and appointed for the Company on January 30, 2013.

The group policy was terminated on January 15, 2014 and since the agency was not licensed in Alabama, the Company did not pay any

commissions to the agency. The premiums received by the Company from the effective date of January 15, 2013 through December 31, 2013 totaled \$16,865.

Producer 4 (commercial):

Five group applications were submitted by an agency appointed by the Company on April 10, 2013, which was after the effective date of the policies listed below. The group policies had effective dates of February 1, 2013 and March 1, 2013.

- Policy # 09P8150 was effective February 1, 2013. The premiums received by the Company on the group policy from February 1, 2013 through April 10, 2013 were \$21,251.
- Policy # 08R9646 was effective February 1, 2013. The premiums received by the Company on the group policy from February 1, 2013 through April 10, 2013 were \$17,053.
- Policy # 08R9649 was effective February 1, 2013. The premiums received by the Company on the group policy from February 1, 2013 through April 10, 2013 were \$2,237.
- Policy # 08R9655 was effective February 1, 2013. The premiums received by the Company on the group policy from February 1, 2013 through April 10, 2013 were \$2,676.
- Policy # 09R8680 was effective March 1, 2013. The premiums received by the company on the group policy from March 1, 2013 through April 10, 2013 were \$959.

The premium received on the above five group policies totaled \$44,176. Company management indicated that the Agency began receiving commissions in April 2013.

Producer 5 (commercial)

The group application for policy # 04S3086 was received on May 22, 2013, with an effective date of June 1, 2103. Company management indicated the following:

- The agency was appointed on September 30, 2014, which was after the effective date of the policy. No commissions were paid to the agency.

- Agent was appointed prior to the application date.

The \$8,122 in premiums was determined to be for the period prior to the appointment of the agency and included premiums for July through September 30, 2013.

For producers /agencies 3 and 5, Company management indicated that the writing producers /agents were licensed and appointed for the Company. Alabama Department of Insurance Bulletin No. 2010-06 dated May 17, 2010, which states in paragraph 3:

The requirement for a business entity producer license is not satisfied by individual licensing of entity officers or employees. By the same token, a business entity license does not relieve an individual employee or contractor actually involved in the solicitation, negotiation, or sale of insurance from the legal requirement of having an individual producer license qualified in the appropriate line(s) of authority.

Company management offered the following comments Medicare Advantage policies:

Producers 6, 7 & 8 (Medicare):

The Company confirms that agent 2053616 was not appointed at the time of application for one Medicare Advantage policy and agents 2015379 and 2060158 were not licensed at the time of application for one Medicare Advantage policy each. Federal regulations require that the Company accept the Medicare Advantage applications in these cases, so as not to penalize the Medicare Advantage applicant. We are respectfully requesting the following language be added to the market conduct exam report:

UnitedHealthcare accepts enrollments pursuant to requirements of the Centers for Medicare & Medicaid Services (CMS) that do not give plans discretion to deny enrollment to eligible beneficiaries. CMS regulations provide that except in limited circumstances, Medicare Advantage (MA) plans “must accept without restriction” enrollment requests from individuals who are eligible to elect an MA plan offered by the MA organization and who elect an MA plan during a valid election period. See 42 C.F.R. 422.60. There is no exception that allows a plan to deny a beneficiary’s request for enrollment on the basis that it was submitted by an un-appointed/unlicensed agent.

42 FR 422.60 states (in part):

(a) Acceptance of enrollees: General rule. (1) Except for the limitations on enrollment in an MS MSA plan provided by §422.62(d)(1) and except as specified in paragraph (a)(2) of this section, each MA organization must accept without restriction (except for an MA RFB plan as provided by §422.57) individuals who are eligible to elect an MA plan that the MA organization offers and who elect an MA plan during initial coverage election periods under §422.62(a)(1), annual election periods under §422.62(a)(2), and under the circumstances described in §422.62(b)(1) through (b)(4). (2) MA organizations must accept elections during the open enrollment periods specified in §422.62(a)(3), (a)(4), and (a)(5) if their MA plans are open to new enrollees.

The three Medicare producers were included in the above chart based on the fact that the producers were not appointed at the time of sale /enrollment of the policies. Producers 2015379 and 2060158 were terminated for unqualified sales.

A similar recommendation was made during the full scope examination dated December 31, 2010 and was repeated during the target examination dated April 30, 2012 – See COMPLIANCE WITH PREVIOUS RECOMMENDATIONS – Page 56

Amounts Classified as Incentive Pay

The Company included “Employee Incentive Pay” as Salaries and Wages in its Annual Statement. Two types of employed agents were eligible to receive incentive payments: Individual Sales Representatives (ISR) also referred to as employed field agents, and Employed Telesales Agents. The Company indicated there were five ISRs working in Alabama. Licensure and appointment are required for both ISRs and Employed Telesales Agents to participate in the incentive program.

Independent agents/producers are not eligible for incentive pay in addition to commissions.

The following list comprises the criteria for an employee to receive incentive pay:

- A range of sales and customer service activities;
- Sales or enrollments that they personally facilitate, including enrollment of individuals new to Medicare, individuals new to a UHC Medicare Advantage plan or individuals switching from one UHC Medicare Advantage plan to another UHC Medicare Advantage plan;

- Leads that result in an enrollment by another agent;
- The member's enrollment must be accepted by the Centers for Medicare & Medicaid Services (CMS);
- The member must remain enrolled in the plan for at least four months.

Incentive pay is part of a targeted commissions' structure. Sales made become part of a pool, of which the amounts in the aggregate pool determines the payout. Telesales employees work the entire 50 states, so the pool is comprised of sales from the entire country, which are then split out among the employees. Specific amounts cannot be determined and cannot be traced to any individual.

Documentation of incentive payments at an employee level does not exist. The payments are passed down to the Company by means of an allocation of management fees. These payments are included in the management fees that UHS charges to the Company pursuant to the management agreement. They are then allocated to the appropriate expense classification item (Salary, wages and other benefits) as if they had been borne directly by the Company, pursuant to Annual Statement Instructions.

The amount reported on the 2012 and 2013 Annual Statements for salaries, wages and other benefits was \$13,424,909 and \$10,659,284, respectively. Of these amounts, the Company estimated that \$499,253 and \$668,760 was allocated to incentive pay for ISRs and Employed Field Agents for the respective years.

A sample of 88 items was selected from ISR, and Employed Telesales Agents listings. The producers in the sample items were appropriately appointed by the Company at the time of sale /enrollment of the policy/policies.

Amounts Classified as Consulting Services

Five telesales vendors were utilized by the Company, who employed and/or contracted with independent agents to perform telesales services. The Company provided the following appointment and licensure information for these telesales vendors:

Vendor	AL Licensee Number	Appointment Date
APAC CUSTOMER SERVICE	272561	5/4/13
TELETECH HEALTHCARE	669141	9/11/13
AEGIS COMMUNICATIONS	265656	3/16/12
CONNEXIONS HCI LLC	239442	9/13/11
TPUSA, INC.	198093	9/9/12

The Company classified the payments to these five telesales vendors as “Consulting Services” in the Annual Statement. Payments are made to the telesales vendor, not to the individual agents or employees.

Regarding the amount paid for Consulting Services for the year of 2013 under examination, consultant services payments are passed down to the Company by means of an allocation of management fees, so it is difficult to have an exact number. Calculating an estimate of the allocation based on actual invoices received from the five cited telesales vendors, was \$623,580.

In the telesales vendor agreements, the term “marketing” is defined as the act of “steering, or attempting to steer, an undecided potential enrollee towards a plan, or promoting a plan or a number of plans.”

It was not possible to identify which telesales agents received payments, and for how much, since the payments are passed down to the Company by means of an allocation of management fees, as described above.

The most current marketing agreements were revised and effective on May 1, 2013. The agreements specify, “Licensed Agents are prohibited from enrolling into any product a Consumer residing in a state in which the Agent is not fully licensed, certified and appointed.”

Controls are in place whereby a message appears if an agent creates or updates a lead opportunity in a state where the agent is not currently licensed reminding the agent of compliance requirements.

The new policy listing was reviewed to identify any of the consulting services firms produced business while they were not appointed. There were no issues noted.

Terminated Producers

A sample of 116 from a population of 12,509 terminated producers was reviewed to determine if the Alabama Department of Insurance (ALDOI) was notified of the termination within thirty days following the effective date of the termination. The examiners determined the following:

1. The Company did not file the termination notice with ALDOI in a timely manner for two producers where the termination was not for cause.

2. The Company did not send the termination of cause notice to ALDOI for three other producers.

The Company did not comply with ALA. CODE § 27-7-30 (e) (1975), which states:

Subject to the producer's contract rights, if any, an insurer or authorized representative of the insurer may terminate a producer's appointment at any time. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason shall within 30 days following the effective date of the termination, using a format prescribed by the commissioner, give notice of the termination to the commissioner.

For one producer where the termination was not for cause, the Company disagreed with the findings. Company management indicated the following:

Initially this producer was to be termed on August 26, 2013; however, the producer changed his roles to become a telesales agent and remain appointed with UHC. The telesales agent was subsequently termed effective December 7, 2013. The termination letter was sent to the producer on December 11, 2013 and the ALDOI was notified to terminate the appointment on December 11, 2013.

The documents reviewed indicated that via a letter dated August 23, 2013, the producer requested termination of the existing appointment by UHS. The Company's termination letter was dated August 26, 2013, which terminated the appointment effectively August 26, 2013. This letter was not followed by notification of the termination to ALDOI through the NIPR.

Company management provided another termination of appointment letter to the producer dated December 11, 2013, with the termination effective December 7, 2013. This termination letter included a notice to ALDOI filed through the NIPR dated December 13, 2014.

A similar recommendation was made during the previous full scope examination dated December 31, 2010. See COMPLIANCE WITH PREVIOUS RECOMMENDATIONS – Page 56

Privacy Policy
Compliance with ALA. ADMIN. CODE 482-1-122

The Company is a health maintenance organization and is required to comply with the federal privacy laws.

The Company provides privacy notices to its enrollees and prospective insureds which disclose the types of non-public personal information collected, and the manner in which the information is used. The notices state that the Company does not disclose personal financial information about their enrollees to any third party, except as required or permitted by law. The notice also states that the enrollee has the right to ask to restrict the use or disclosure of their information for treatment, payment, or healthcare operations.

The Company has policies in place to inform its employees of the informational privacy standards, which state that the employee is required to reasonably and appropriately safeguard personal information, and to use or disclose such information only as permitted by the individual or in compliance with all applicable laws. The Company also has policies in place to outline the procedures to be followed by the employees in the handling of the enrollees' non-public personal financial information.

Formal agreements are maintained with third party providers to identify the roles and responsibilities, the expected deliverables, the performance standards, and the credentials required of the third party.

The HMO's disclosure of any personal health information was made only after authorization from its enrollees, unless the disclosures were made in accordance with the applicable federal privacy laws.

FINANCIAL CONDITION/GROWTH OF THE COMPANY

The following schedule presents financial data taken from copies of filed annual statements, which reflects the growth of the Company for the years indicated:

<u>Year</u>	<u>Net premium</u> <u>Income</u>	<u>Admitted</u> <u>Assets</u>	<u>Liabilities</u>	<u>Capital and</u> <u>Surplus</u>
2010*	\$ 375,074,781	\$ 100,608,513	\$ 55,847,941	\$ 44,760,572
2011	405,297,975	125,614,174	62,862,141	62,752,033
2012	412,359,714	134,012,371	62,759,561	71,252,810
2013*	404,520,884	132,711,104	70,291,170	62,419,934

* Data for the years 2010 and 2013 are per the examination. Data for the remaining years was obtained from the Company's Annual Statements.

REINSURANCE

Reinsurance Assumed

The Company did not assume any business during the period covered by the examination.

Reinsurance Ceded

Effective January 1, 2005, the Company entered into an Insolvency Reinsurance Agreement with UnitedHealthcare Insurance Company (reinsurer). The agreement was filed with and approved by the Commissioner of the Alabama Department of Insurance on December 17, 2004. Under the terms of the agreement, in the event of the Company's insolvency, the reinsurer will provide payments directly to the Company's liquidator, receiver or statutory successor on the basis of liability under the policies of the Company without diminution for the insolvency or failure to pay by the liquidator, receiver or statutory successor. The reinsurer will accept the Company's obligations with respect to losses paid or payable for health care services rendered on or prior to insolvency of the Company by providers that were not under contract to the Company. In addition, members shall have their coverage continued for the period for which their premiums have been paid and benefits will be continued to members confined in an inpatient facility on the date of insolvency until their discharge or coverage under a health benefit plan by another carrier. The reinsurer will not be responsible for claims if notice of claim has not been received in writing within two years of the insolvency date.

Premiums ceded during the period covered by the examination as reported in *Schedule S - Part 3 - Section 2* of the Annual Statements indicated the following:

<u>Year</u>	<u>Amount</u>
2011	\$ 407,202
2012	411,374
2013	<u>406,270</u>
Total	\$ <u>1,224,846</u>

No reinsurance credit was taken by the Company during the years under examination. See Insolvency Reinsurance Agreement – Page 27 under the caption Transactions and Agreements with Affiliates.

ACCOUNTS AND RECORDS

The Company's general accounting records consisted of an automated general ledger and various subsidiary ledgers. The record keeping functions are performed in Minnetonka, Minnesota by United HealthCare Services Inc. (UHS). Our review of the records did not disclose any significant deficiencies in these records, unless noted elsewhere in this Report.

The Company's principal accounting records were maintained on electronic data processing equipment. Management and record-keeping functions were performed by the personnel of UHS under the terms of a Management Services Agreement. See the caption "*Management Services Agreement*" – Page 17.

External Auditors

The Company was audited annually by the certified public accounting firm of Deloitte & Touche, LLP, Minneapolis, Minnesota. The audit workpapers for the three-year examination period were provided and used as deemed appropriate.

EXHIBIT PREMIUMS WRITTEN

The following information is taken from the 2013 Annual Statement:

Schedule T – Premiums and Other Considerations

<u>State</u>	<u>Amount</u>
Alabama	\$ <u>404,927,154</u>
Total Premiums Written	\$ <u>404,927,154</u>

FINANCIAL STATEMENTS

Financial statements included in this report, which reflect the financial condition of the Company at December 31, 2013, and its operations for the years under examination, consist of the following:

	<u>Page</u>
Statement of Assets	50
Statement of Liabilities, Capital and Surplus	51
Statement of Revenue and Expenses	52
Statement of Changes of Capital and Surplus	53

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

UNITEDHEALTHCARE OF ALABAMA, INC.
STATEMENT OF ASSETS
For the Year Ended December 31, 2013

	<u>Assets</u>	<u>Assets Not Admitted</u>	<u>Net Admitted Assets</u>	<u>Prior Year Net Admitted Assets</u>
ASSETS				
Bonds	\$ 103,890,183	\$ -0-	\$ 103,890,183	\$ 102,601,777
Cash, cash equivalents and short-term investment	5,178,319		5,178,319	12,049,625
Investment income due and accrued	964,435		964,435	994,871
Uncollected premiums and agents' balance in the course of collection	10,279,225	88,775	10,190,450	1,531,515
Amounts receivable relating to uninsured plans	3,868,233	45,952	3,822,281	3,171,217
Current federal and foreign income tax recoverable and interest thereon	0		0	4,302,926
Net deferred tax asset	790,426		790,426	863,245
Guaranty funds receivable or on deposit	68,015		68,015	42,573
Health care and other amounts receivables	9,432,675	1,637,889	7,794,786	8,445,366
Aggregate write-ins for other than invested assets	<u>12,209</u>	<u>0</u>	<u>12,209</u>	<u>9,256</u>
TOTAL ASSETS	\$ <u>134,483,720</u>	\$ <u>1,772,616</u>	\$ <u>132,711,104</u>	\$ <u>134,012,371</u>

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

UNITEDHEALTHCARE OF ALABAMA, INC.
STATEMENT OF LIABILITIES, CAPITAL AND SURPLUS
For the Year Ended December 31, 2013

	<u>Covered</u>	<u>Total</u>	<u>Prior Year</u> <u>Total</u>
Liabilities:			
Claims unpaid	\$ 47,631,371	\$ 47,631,371	\$ 51,025,322
Accrued medical incentive pool and bonus amounts	263,594	263,594	98,722
Unpaid claims adjustment expenses	427,600	427,600	966,751
Aggregate health policy reserves	1,359,533	1,359,533	3,031,667
Aggregate health claim reserves	51,137	51,137	60,280
Premiums received in advance	110,512	110,512	66,598
General expenses due or accrued	188,535	188,535	986,208
Current federal and foreign income tax payable and interest thereon	1,497,113	1,497,113	0
Ceded reinsurance premiums payable	32,873	32,873	35,474
Remittance and items not allocated	13,148	13,148	4,151
Amounts due to parent, subsidiaries and affiliates	17,289,842	17,289,842	5,374,148
Liability for amounts held under uninsured plans	340,884	340,884	1,087,244
Aggregate write-in for other liabilities	<u>1,085,028</u>	<u>1,085,028</u>	<u>22,996</u>
Total Liabilities	\$ <u>70,291,170</u>	\$ <u>70,291,170</u>	\$ <u>62,759,561</u>
Capital and Surplus:			
Common capital stock		\$ 100,328	\$ 100,328
Preferred capital stock		20,000	20,000
Gross paid in and contributed surplus		17,563,520	17,563,520
Unassigned funds (surplus) (Note 1)		44,792,336	53,625,212
Less treasury stock, at cost (15,000 shares common)		56,250	56,250
Total capital and surplus		\$ <u>62,419,934</u>	\$ <u>71,252,810</u>
Total liabilities, capital and surplus	XXX	\$ <u>132,711,104</u>	\$ <u>134,012,371</u>

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

UNITEDHEALTHCARE OF ALABAMA, INC.
STATEMENT OF REVENUE AND EXPENSES
For the Years Ended December 31, 2013, 2012 and 2011

	<u>2013</u>	<u>2012</u>	<u>2011</u>
MEMBER MONTHS	471,526	457,240	432,667
Net premium income	\$ 404,520,884	\$ 412,359,714	\$ 405,297,975
Change in unearned premium reserves and reserve for rate credits	<u>1,672,134</u>	<u>-1,251,771</u>	<u>6,870</u>
Total revenues	\$ <u>406,193,018</u>	\$ <u>411,107,943</u>	\$ <u>405,304,845</u>
<u>Medical and Hospital:</u>			
Hospital/medical benefits	\$ 304,681,170	\$ 288,732,265	\$ 278,458,411
Other professional services	266,855	650,961	769,604
Prescription drugs	23,521,956	23,494,187	25,005,779
Incentive pool, withhold adjustments, and bonus amounts	<u>250,973</u>	<u>75,596</u>	<u>137,437</u>
Subtotal	\$ <u>328,720,954</u>	\$ <u>312,953,009</u>	\$ <u>304,371,231</u>
<u>Less:</u>			
Net reinsurance recoveries			
Total hospital and medical	\$ 328,720,954	\$ 312,953,009	\$ 304,371,231
Claims adjustment expenses	13,894,004	11,845,997	10,639,436
General administration expenses	26,158,140	29,340,744	29,324,532
Increase in reserves for life and accident and health contracts	<u>0</u>	<u>0</u>	<u>-0-</u>
Total underwriting deductions	\$ <u>368,773,098</u>	\$ <u>354,139,750</u>	\$ <u>344,335,199</u>
Net underwriting gain or (loss)	\$ <u>37,419,920</u>	\$ <u>56,968,193</u>	\$ <u>60,969,646</u>
Net investment income earned	2,526,431	2,658,750	2,178,730
Net realized capital gains or (losses)	<u>296,369</u>	<u>202,947</u>	<u>61,769</u>
Net investment gains or (losses)	\$ <u>2,822,799</u>	\$ <u>2,861,697</u>	\$ <u>2,240,499</u>
Net gain or (loss) from agents' or premium balance charged off	-46,567	-61,878	
Aggregate write-ins for other income or expenses	5	-25,000	0
Net income or (loss)	\$ <u>40,196,157</u>	\$ <u>59,743,012</u>	\$ <u>63,210,145</u>
Federal and foreign income taxes incurred	\$ <u>13,497,757</u>	\$ <u>20,452,693</u>	\$ <u>21,866,653</u>
Net income (loss)	\$ <u>26,698,400</u>	\$ <u>39,290,319</u>	\$ <u>41,343,492</u>

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

UNITEDHEALTHCARE OF ALABAMA, INC.
STATEMENT OF CHANGES IN CAPITAL AND SURPLUS
For the Years Ended December 31, 2010, 2009 and 2008

	<u>2013</u>	<u>2012</u>	<u>2011</u>
Capital and surplus prior reporting year	\$ 71,252,810	\$ 62,752,033	\$ 44,760,572
GAINS & LOSSES TO CAPITAL & SURPLUS:			
Net income or (loss)	\$ 26,698,400	\$ 39,290,319	\$ 41,343,492
Change in net unrealized capital gains (losses)			
Change in net deferred income tax	- 72,820	404,571	96,742
Change in nonadmitted assets	41,544	-1,194,113	1,274,068
Dividends to stockholders	-35,500,000	-30,000,000	-20,000,000
Aggregate write-ins for gains or (losses) in surplus	<u>-0-</u>	<u>-0-</u>	<u>-4,722,841</u>
Net change in capital and surplus	\$ <u>-8,832,876</u>	\$ <u>8,500,777</u>	\$ <u>17,991,461</u>
Capital and surplus end of reporting period (rounding)	\$ <u>62,419,934</u>	\$ <u>71,252,810</u>	\$ <u>62,752,033</u>

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

NOTES TO FINANCIAL STATEMENTS

Note 1 – Unassigned funds (surplus)

\$ 44,792,336

Unassigned funds (surplus), as determined by this examination, were the same as reported by the Company in its 2013 Annual Statement. No changes were made to the financial statements in this report.

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CONTINGENT LIABILITIES AND PENDING LITIGATION

The review of contingent liabilities and pending litigation included:

- An inspection of representation made by management to the Company's independent certified public accountants regarding the Company.
- A review of the report on litigation and claims made by the Chief Legal Officer of UnitedHealth Group Incorporate and affiliates to the Company's independent certified public accountants.
- A review of the representation made by management to the examiners.
- A review of the report to the examiners on pending litigation as of December 31, 2013 and from that date to the date of the Company's response made by Company management.
- A review of the Company's records and files conducted during the course of the examination, including a review of claims, and
- A review of the Company's statutory financial statement disclosures, minutes of the sole Shareholder, Board of Directors and Southeast Region Audit Committee.

The Company made the following disclosures under Note 14 E - *All Other Contingencies* in its statutory financial statement:

The Company's business is regulated at the federal, state and local levels. The law and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk adjustment model.

RADV Audit – CMS adjusts capitation payment to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then

determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

CMS and the office of the Inspector General for Health and Human Services periodically perform RADV audits of selected Medicare health plans to validate the coding practices of any supporting documentation maintained by health care providers. Such audits have in the past resulted and could in the future result in retrospective adjustments to payment made to the Company, fines, corrective action plans or other adverse action by CMS.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audit beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

Health Reform Legislation and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative cost, expose the Company to an increased risk of liability (including increasing the Company's liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's statutory basis results of operations, financial condition, including the ability to maintain the value of goodwill, and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

Compliance with Producers' Licensing Requirements - Page 37

A review was conducted during the current examination with regard to Company's compliance with the recommendation made in the previous full-scope examination and the target exam dated April 30, 2012 reports. The Company had not complied with the following recommendations.

It is again recommended that the Company only accept business from producers appointed by the Company and comply with ALA. CODE § 27-7-4 (1975), which states:

(a) No person shall in this state sell, solicit, or negotiate insurance for any class or classes of insurance unless the person is then licensed for that line of authority in accordance with this chapter. Any insurer accepting business directly from a person not licensed for that line of authority and not appointed by the insurer shall be liable to a fine up to three times the premium received from the person.

The following recommendation was made in the previous examination:

It is again recommended that the Company notify the Alabama Department of Insurance within thirty days following the effective date of the termination of a producer. If a producer is terminated for cause, the termination for cause notice should be sent to ALDOI within thirty days as required by ALA. CODE § 27-7-30 (e) (1975), which states:

Subject to the producer's contract rights, if any, an insurer or authorized representative of the insurer may terminate a producer's appointment at any time. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason shall within 30 days following the effective date of the termination, using a format prescribed by the commissioner, give notice of the termination to the commissioner

COMMENTS AND RECOMMENDATIONS

Advertising and Marketing - Page 35

It is recommended that the Company include the name and address of the Company in all advertisements as required by ALA. ADMIN CODE 482-1-079-.06(1987), which states:

All advertisements must contain the name and address of the HMO as filed with the Commissioner.

Claim Payment Practices - Page 35

It is recommended that the Company maintain all claims filing records and provide the same when requested by the examiners and comply with ALA. CODE § 27-21A-16 (f) (1975), which states:

(f) All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner.

It is recommended that the Company make the claim payments within 45 days from the receipt of the claims in accordance with the guidance provided by ALA. ADMIN. CODE 482-1-079-.18 (1987), which states:

All licensed HMO's shall consider claims made under their health care contracts and, if found to be valid and proper, shall pay such claims within forty-five (45) days after the receipt of proof of the fact and amount of loss sustained under such contracts.

It is recommended that the Company maintain the claim documents for claims which were denied or closed without payment and provide the same to the examiners and comply with ALA. CODE § 27-21A-16 (f) (1975), which states:

All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner.

Compliance with Producers' Licensing Requirements - Page 37

It is recommended that the Company only accept business from producers who are appointed by the Company as required by

ALA. CODE § 27-7-4 (1975), which states:

(a) No person shall in this state sell, solicit, or negotiate insurance for any class or classes of insurance unless the person is then licensed for that line of authority in accordance with this chapter. Any insurer accepting business directly from a person not licensed for that line of authority and not appointed by the insurer shall be liable to a fine up to three times the premium received from the person.

It is recommended that the Company notify the Alabama Department of Insurance within thirty days following the effective date of the termination of a producer. If a producer is terminated for cause, the termination for cause notice should be sent to ALDOI within thirty days as required by ALA. CODE § 27-7-30 (e) (1975), which states:

Subject to the producer's contract rights, if any, an insurer or authorized representative of the insurer may terminate a producer's appointment at any time. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason shall within 30 days following the effective date of the termination, using a format prescribed by the commissioner, give notice of the termination to the commissioner

SUBSEQUENT EVENTS

- Mr. Russell Conrad Petrella Chairman, Chief Executive Officer, and President of the Company resigned on April 30, 2014, and replaced by Mr. Dennis Patrick O'Brien. Mr. Petrella was elected to the Board on December 20, 2013.
- Robert James Friedrichs, Chief Financial Officer Southeast Region, United Healthcare Services, Inc. was removed effectively April 18, 2014 and replaced by Mr. Stephen Lewis Wilson.
- Various related party contracts were amended or replaced – See Transactions and Agreements with Affiliates – Page 16.

CONCLUSION

Acknowledgement is hereby made of the courtesy and cooperation extended by all persons representing the Company during the course of the examination.

The customary examination procedures, as recommended by the National Association of Insurance Commissioners for health maintenance organizations, have been followed in connection with the verification and valuation of assets and the determination of liabilities set forth in this report.

The examination of the Company was coordinated with the examination of four New York companies performed by the New York Department of Financial Services (NYDFS). Alabama Department of Insurance relied on the examination work performed by NYDFS as part of the coordinated examination of the companies. The undersigned performed procedures specific to the Alabama Company and determined Company's compliance with Alabama Laws and Regulations. Market Conduct procedures included a review of Territory, Plan of Operation, Policy Forms, Rates and Underwriting Practices, Advertising and Marketing, Claims Payment Practices, Policyholder Complaints, Compliance With Producers' Licensing Requirements and Privacy Policy.

Respectfully submitted,

Francis Blase Abreo

Blase Abreo, CFE
Examiner-in-Charge
Alabama Department of Insurance