

**NORTH CAROLINA DEPARTMENT OF INSURANCE
RALEIGH, NORTH CAROLINA**

STATE OF NORTH CAROLINA

**BEFORE THE COMMISSIONER
OF INSURANCE**

COUNTY OF WAKE

**IN THE MATTER OF UNITED
HEALTHCARE INSURANCE COMPANY
and UNITEDHEALTHCARE OF
NORTH CAROLINA, INC.**

**VOLUNTARY SETTLEMENT
AGREEMENT**

WHEREAS, the North Carolina Department of Insurance (hereinafter "NCDOI") is charged with the authority and responsibility for the enforcement of the insurance laws of the State of North Carolina; and

WHEREAS, United HealthCare Insurance Company is a Connecticut corporation licensed by NCDOI to transact life and health insurance business in North Carolina; and

WHEREAS, UnitedHealthcare of North Carolina, Inc. is a North Carolina corporation licensed by NCDOI to act as a health maintenance organization (HMO) in North Carolina; and

WHEREAS, United HealthCare Insurance Company provides health insurance to citizens and businesses in North Carolina; and

WHEREAS, UnitedHealthcare of North Carolina, Inc. is a Health Maintenance Organization (HMO) that provides managed care health plans to citizens and businesses in North Carolina; and

WHEREAS, United HealthCare Insurance Company and UnitedHealthcare of North Carolina, Inc. (hereinafter "the UHC Companies") are affiliated companies that are properly joined in this Voluntary Settlement Agreement and that are properly required to jointly comply with the obligations and duties hereunder; and

WHEREAS, NCDOJ has received health care provider and consumer complaints regarding the claim processing and claim payment practices of the UHC Companies; and

WHEREAS, in November of 2004, based upon reported complaint data and other information, NCDOJ entered into a Voluntary Settlement Agreement (the "2004 VSA") with the UHC Companies. The 2004 VSA focused on the UHC Companies' compliance with certain insurance and health maintenance organization laws primarily related to the UHC Companies' utilization of UNet and Cosmos, two multistate national platforms that provide administrative services, including claims payment services (collectively the "UHC Platform"). The areas of concern identified included claims handling and other insurance administrative practices and the compliance of those practices with the laws of North Carolina; and

WHEREAS, in compliance with the 2004 VSA, the UHC Companies began making trade secret reports to NCDOJ regarding their process improvements in the areas of concern identified in that VSA, including claims handling and other insurance administrative practices and the compliance of those practices with the laws of North Carolina; and

WHEREAS, as of August 27, 2007, the UHC Companies, and affiliated companies, entered into an agreement with a number of state insurance regulators outside of North Carolina, hereinafter referred to as the "Multistate Agreement." In said Multistate Agreement, certain regulators were established as "Lead Regulators;" and

WHEREAS, NCDOJ and the UHC Companies desire that, regarding past violations of North Carolina law, this Agreement shall mirror certain provisions of the Multistate Agreement; and

WHEREAS, NCDOJ has identified certain areas of concern that the UHC Companies have agreed should be subject to review on a collaborative basis (the "Multistate Areas of

Review"). The Multistate Areas of Review are set forth in Exhibit A to this Agreement; and

WHEREAS, the UHC Companies are willing and desirous to resolve all issues relative to the Multistate Areas of Review which occurred prior to August 27, 2007; and

WHEREAS, the parties agree that nothing in this Agreement limits or restricts NCDOI's regulatory or disciplinary power or authority with regard to violations by the UHC Companies of applicable laws or regulations that take place after August 27, 2007; and

WHEREAS, the parties agree that NCDOI may take any and all action it is authorized to take should it determine that the UHC Companies have violated any provision of North Carolina insurance laws and regulations outside the scope of the Multistate Areas of Review and other previously settled matters, as well as with respect to individual consumer or provider complaints; and

WHEREAS, NCDOI desires to participate in the ongoing investigation and examination by the Lead Regulators concerning the monitoring of the UHC Companies for compliance with the Multistate Agreement; and

WHEREAS, NCDOI shall be conducting a follow-up market conduct examination of UnitedHealthcare of North Carolina, Inc. concerning the areas of review set forth in Exhibit E of this Agreement within the 2006 VSA which are not covered by the Multistate Areas of Review; and

WHEREAS, except for the exclusion of violations, including any alleged violations of North Carolina insurance laws or regulations, within the scope of the Multistate Areas of Review which occurred prior to August 27, 2007, the parties agree that nothing in this Agreement limits or restricts NCDOI's regulatory or disciplinary power or authority with regard to violations, including past violations, of applicable laws or regulations found by said market conduct

examination; and

WHEREAS, pursuant to N.C.G.S. § 58-2-70(g), the Commissioner of Insurance and NCDOI have the express authority to negotiate “a mutually acceptable agreement with any person as to the status of the person’s license or certificate or as to any civil penalty or restitution;” and

WHEREAS, the UHC Companies and NCDOI have reached a mutually-agreeable resolution of those matters set out in this Voluntary Settlement Agreement;

NOW, THEREFORE, it is agreed by and between NCDOI and the UHC Companies as follows:

A.1. The Multistate Areas of Review are set forth in Exhibit A to this Agreement.

A.2. United HealthCare Insurance Company and UnitedHealthcare of North Carolina, Inc. agree to pay a monetary penalty in the total amount of \$786,655.87 to NCDOI in settlement of their responsibility for any past violations, or alleged violations, of North Carolina insurance laws or regulations pertaining to the Multistate Areas of Review as described in Exhibit A which occurred prior to August 27, 2007--the effective date of the 2007 Multistate Agreement. The check in payment of this penalty shall be delivered to NCDOI at the time of the execution of this Voluntary Settlement Agreement and simultaneously with forwarding the Voluntary Settlement Agreement to NCDOI for execution. Said monetary penalty shall be subject to disbursement in accordance with the provisions of Article IX, Section 7 of the North Carolina Constitution, and thus shall inure to the benefit of the public schools.

A.3. This Agreement supersedes all prior agreements between the parties, including the 2004 and 2006 VSA, to the extent its terms are inconsistent therewith. This Agreement is not intended to re-open matters that have been previously settled by agreement between the parties. Notwithstanding, the reporting requirements herein shall replace all existing reporting

requirements related to either the 2004 or 2006 VSA that are not otherwise required by law.

B.1. By entering into this Voluntary Settlement Agreement, the UHC Companies do not admit to any violations of North Carolina insurance statutes or administrative rules.

B.2. The parties to his Agreement agree that this Agreement shall have the full force and effect of an Order of the Commissioner.

C.1. The UHC Companies in cooperation with the Lead Regulators named in the 2007 Multistate Agreement have developed a process improvement plan attached as Exhibit B to this Agreement (the "Process Improvement Plan") to address, resolve, and monitor the Multistate Areas of Review. The UHC Companies shall commence implementation of the Process Improvement Plan within thirty (30) days of the execution of this Agreement. The Process Improvement Plan may be modified or amended pursuant to the Multistate Agreement, or by mutual agreement of the parties hereto.

C.2. Compliance with the Process Improvement Plan will be determined by the standards developed by the Lead Regulators under the Multistate Agreement and the UHC Companies as set forth in Exhibit C to this Agreement (the "Benchmarks") and measured on a nationwide basis (utilizing national data). The UHC Companies shall meet the tolerance standards established for the Benchmarks on or before the dates set forth in Exhibit C. The UHC Companies shall be deemed to have satisfied the Process Improvement Plan requirements if the performance of the UHC Companies falls within the tolerances standards established in the Benchmarks, as set forth in Exhibit C, provided that the measures established in the Benchmarks are equivalent to, or superior to, compliance with North Carolina law ("Compliance").

C.3. The UHC Companies shall make restitution to their past or present insureds and providers in the ordinary course of business through the reprocessing of identified erroneous

claims resulting from claim processing errors. Additionally, through the implementation of the Process Improvement Plan, where the UHC Companies or Lead Regulators or NCDOI determine that less than appropriate claims payments were made for specific valid claims, the UHC Companies agree to make restitution and make all other appropriate adjustments on such claims, including the payment of interest as required by the laws of North Carolina within a reasonable time after making such determination. In the event the UHC Companies or Lead Regulators or NCDOI determine that less than appropriate claim payments were made for valid claims on a systemic basis due to an identifiable error in the UHC Companies' Platform (a "System Error"), the UHC Companies agree to conduct an internal review and to make restitution and all other appropriate adjustments on such claims, including the payment of interest as required by applicable law within a reasonable time after making such determination. The period of such review shall be retroactive to the date the System Error first resulted in a failure to properly pay a claim, but in no event shall such a review cover periods more than sixty (60) months immediately prior to the effective date of this Agreement.

C.4. The Lead Regulators established under the Multistate Agreement will monitor the UHC Companies' Compliance with the Benchmarks. The UHC Companies agree to meet with the said Lead Regulators at least quarterly to report their progress in implementing the terms of the Multistate Agreement, including, but not limited to, any restitution paid.

C.5. At least ten (10) business days prior to each such meeting, the UHC Companies agree to deliver to the Lead Regulators written reports in the format set forth in Exhibit D to this Agreement. Each report shall be due and delivered to the Lead Regulators within sixty (60) days of the end of a calendar year quarter with the first report covering the period of the fourth quarter of 2007. NCDOI will, in its discretion, request copies of these reports and other examination

materials from the Lead Regulators.

C.6. Under the Multistate Agreement, the UHC Companies agreed to retain, at their expense, the services of an independent examiner ("Examiner") for the purpose of assisting the Lead Regulators in monitoring the UHC Companies' compliance with the Multistate Agreement. The Examiner's responsibilities shall include: conducting three (3) annual compliance reviews (the "Annual Compliance Reviews") and preparing written reports of such reviews for the Lead Regulators under the Multistate Agreement and the UHC Companies; reviewing the UHC Companies' progress in implementing the Process Improvement Plan; assessing the accuracy and validity of the UHC Companies' quarterly reports by conducting sampling in accordance with the standards provided in the NAIC's Market Regulation Handbook; and assessing the UHC Companies' compliance under the Multistate Agreement. The UHC Companies and NCDOI will request that the Lead States and the Examiner include North Carolina data as defined in Attachment 1 to Exhibit C in its examination activities of UHC Companies' Compliance. To the extent permitted by the Lead Regulators NCDOI, where practical, plans to participate in the Lead Regulator's examination/investigation activities.

C.7. Following the completion of each of the first and second Annual Compliance Reviews under the Multistate Agreement, if the Lead Regulators under said Multistate Agreement, determine that the UHC Companies are not in Compliance with the Benchmarks applicable to the time period covered by such review, the UHC Companies agree to work with NCDOI to determine the cause of such non-Compliance and, if necessary, develop an amended Process Improvement Plan to address such issues. In the event that NCDOI and the UHC Companies cannot resolve such issues, NCDOI may take any appropriate action permitted by North Carolina law that does not relate to deficiencies concerning the Multistate Areas of

Review occurring prior to August 27, 2007.

C.8. Even if the UHC Companies are in Compliance with the Benchmarks, if there are deficiencies, involving compliance with respect to the Multistate Areas of Review in North Carolina, the UHC Companies agree to work with NCDOI to resolve such issues, including the development of an amended Process Improvement Plan, if necessary. In the event that NCDOI and the UHC Companies cannot resolve such issues, NCDOI may take any appropriate action permitted by North Carolina law that does not relate to deficiencies concerning the Multistate Areas of Review occurring prior to August 27, 2007.

C.9. Except as otherwise set forth in paragraph C.10. herein, with respect to the period of time preceding this Agreement, NCDOI will not impose an additional monetary penalty, sanction,, injunction or any other remedy on the UHC Companies for any past failures, including any alleged violations of North Carolina insurance laws or regulations, of the UHC Companies to comply with the Multistate Areas of Review which occurred prior to August 27, 2007.

C.10. Notwithstanding any other provision of this Agreement, NCDOI may take any and all appropriate action should it determine that the UHC Companies have violated any provision of North Carolina insurance laws and regulations outside the scope of the Multistate Areas of Review.

C.11. To the extent permitted by the Lead Regulators, NCDOI, where practical, plans to participate in the examination of the Lead Regulators concerning the Compliance of the UHC Companies. The Lead Regulator's monitoring of the UHC Companies constitutes an ongoing investigation and examination by the State of Iowa, as a Lead Regulator, pursuant to Iowa law. To the extent permitted by law all reporting to the Lead Regulators and NCDOI hereunder will be facilitated through the state of Iowa, and the work papers, recorded information, documents,

and copies of work papers, recorded information, and documents produced by, obtained by or disclosed to NCDOI under this Agreement shall be given confidential treatment and shall not be subject to subpoena and may not be made public by NCDOI or to any other person, and shall not be public records subject to disclosure pursuant to other relevant law.

C.12. While NCDOI plans to participate in the multistate examination activities of the Lead Regulators and will not duplicate such examination activities, NCDOI reserves its statutory right to examine and investigate the UHC Companies as authorized by North Carolina law.

C.13. This Agreement is not intended and may not be construed to limit the authority of NCDOI's Consumer Services Division in investigating and taking appropriate action with regard to a consumer or provider complaint.

D.1. By entering into this Agreement NCDOI and the UHC Companies intend to resolve all past instances of non-compliance, including any alleged violations of North Carolina insurance laws or regulations, with respect to the Multistate Areas of Review which occurred prior to August 27, 2007. This Agreement shall be deemed a complete settlement and full and final resolution, and is in lieu of any disciplinary, legal, regulatory or enforcement actions that could have been taken by NCDOI relating to past instances of conduct, including any alleged violations of North Carolina insurance laws or regulations, that did not comply with the Multistate Areas of Review and that occurred prior to August 27, 2007.

D.2. Nothing in this Agreement shall be construed to excuse the UHC Companies from their obligations to properly pay claim(s)s.

D.3. Nothing in this Agreement limits or restricts NCDOI's regulatory or disciplinary power or authority with regard to violations by the UHC Companies of applicable laws or regulations that take place after August 27, 2007.

D.4. Except as otherwise set forth in paragraph D.1. herein, nothing in this Agreement limits or restricts NCDOI's regulatory or disciplinary power or authority with regard to violations by the UHC Companies, including past violations, of applicable laws or regulations that are within the scope of the follow-up market conduct examination of UnitedHealthcare of North Carolina, Inc. concerning the areas of review set forth in Exhibit E of this Agreement within the 2006 Market Conduct VSA which are not covered by the Multistate Areas of Review.

D.5. This Agreement shall be binding on and inure to the benefit of the parties and their respective legal representatives, successors and assigns.

D.6. The failure of NCDOI at any time to require the strict performance by the UHC Companies of any of the terms, provisions or conditions hereof shall in no way affect the right thereafter to enforce the same, nor constitute a waiver by NCDOI of any breach of any terms, provisions and conditions hereof.

D.7. Nothing in this Agreement enlarges, supersedes or preempts the insurance laws or regulations of North Carolina. The UHC Companies agree to comply with all provisions of Chapter 58 of the North Carolina General Statutes and Title 11 of the North Carolina Administrative Code that are applicable to them.

D.8. This Agreement sets forth the entire agreement among the parties with respect to the UHC Companies' conduct regarding any alleged violations of the North Carolina insurance laws or regulations pertaining to the Multistate Areas of Review which occurred prior to August 27, 2007.

D.9. Nothing in this Agreement or any of its terms and conditions shall be interpreted to alter in any way the contractual terms of any insurance policy or health benefit plan.

D.10. Except in a proceeding to enforce the terms hereof, neither this Agreement nor

any related negotiations, statements or court proceedings shall be offered by NCDOI as evidence of or an admission, denial or concession of any liability or wrongdoing whatsoever on the part of any person or entity, including but not limited to the UHC Companies or any affiliates thereof, or as a waiver by the UHC Companies or any affiliates thereof of any applicable defense, including without limitation any applicable statute of limitations or statute of frauds.

D.11. Nothing contained herein shall limit the authority of NCDOI from dealing with specific instances of consumer complaints, licensing changes, rate and form filings, or conducting other regulatory functions. Such regulatory functions shall not be deemed within the scope of this Agreement.

D.12. This Agreement may be signed in multiple counterparts, each of which shall constitute a duplicate original, but which taken together shall constitute but one and the same instrument.

D.13. Nothing herein shall prevent or otherwise restrict NCDOI from pursuing regulatory action against the UHC Companies for regulatory issues, except with respect to the Multi-State Areas of Review that occurred prior to August 27, 2007. Notwithstanding, this provision or other provisions within this Agreement shall not be interpreted to expand NCDOI's regulatory authority with respect to any matter or re-open matters that have been previously settled by the parties hereto.

D.14. In the event that any portion of this Agreement is held invalid by a court of competent jurisdiction, such invalid portion shall be deemed to be severed and all remaining provisions of this Agreement shall be given full force and effect and shall not in any way be affected thereby.

D.15. The UHC Companies understand and agree that by entering into this Agreement,

the UHC Companies waive any and all rights to notice, hearing and appeal respecting past non-compliance with the Multistate Areas of Review which occurred prior to August 27, 2007.

D.16. The UHC Companies shall be excused from performance for any period and to the extent that the UHC Companies are prevented from performing any services, in whole or in part, as a result of delays caused by an act of God, or other cause beyond the UHC Companies' reasonable control, and such nonperformance shall not be considered for determining the UHC Companies' compliance with this Agreement. Notwithstanding the above, the UHC Companies agree to establish and maintain commercially reasonable recovery steps, including technical disaster recovery facilities, uninterruptible power supplies for computer equipment and communications and that as a result thereof the UHC Companies will use commercially reasonable efforts to ensure that the UHC Platform shall be operational within forty eight (48) hours of a performance failure.

D.17. The parties to this Agreement stipulate and agree that NCDONI, by entering into this Voluntary Settlement Agreement, shall not be construed as approving or validating any amounts that the UHC Companies have paid or will pay to persons or entities for claim(s); nor shall NCDONI, by entering into this Voluntary Settlement Agreement, be construed as affecting the legal rights of any third party.

D.18. This Agreement, excluding any confidential reports as described in C.11., when finalized, will be a public record and is not confidential. NCDONI is free to disclose the contents of this Agreement to third parties upon request or pursuant to any law or policy providing for such disclosure.

D.19. Except as otherwise expressly set forth herein, this Agreement does not in any way limit or expand NCDONI's disciplinary power in any future examinations of the UHC

Companies, or regarding any future cases or complaints involving the UHC Companies.

D.20. If the UHC Companies default with respect to any obligation under this Agreement, they shall use commercially reasonable efforts to cure such default as soon as reasonably practicable. If such default is not remedied within ninety (90) business days

following personal delivery or delivery by facsimile of a written notice pursuant to paragraph D.21. specifying such default (during which period NCDOJ and the UHC Companies shall make reasonable efforts to amicably resolve any disputes regarding the default), NCDOJ may seek administrative and/or judicial enforcement of this Agreement.

D.21. All notices permitted or required to be delivered under this Agreement shall be in writing and shall be deemed so delivered by hand, one (1) business day after transmission by facsimile or other electronic system (evidenced by machine generated receipt), five (5) business days after being placed in the hands of a commercial courier service for express delivery, or ten (10) business days after placement in the mails by registered or certified mail, return receipt requested, postage prepaid and addressed to the following addresses or a party's most current principal address of which the party sending the notice has been notified:

If to the UHC Companies: Mitch Zamoff, General Counsel
UnitedHealthcare
5901 Lincoln Drive
Edina, Minnesota 55436

Copy to: Nicholas Thompson, Esq.
Mitchell Williams Selig Gates & Woodyard, PLLC
425 West Capitol Avenue, Suite 1800
Little Rock, Arkansas 72201

If to NCDOJ: Deputy Commissioner
Market Regulation Division
11 South Boylan Avenue
Raleigh, NC 27603

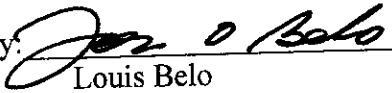
D.22. NCDOJ and the UHC Companies may mutually agree, in writing, to any

reasonable extensions of time that might become necessary to carry out the provisions of this Agreement.

D.23. This Settlement Agreement shall become effective when signed and attested to by the UHC Companies and NCDOL.

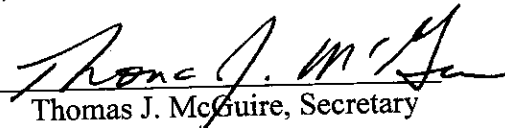
This 22 day of July, 2008.

NORTH CAROLINA DEPARTMENT OF INSURANCE

By: 
Louis Belo
Sr. Deputy Commissioner

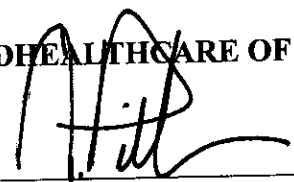
Date: 7/22/08

UNITED HEALTHCARE INSURANCE COMPANY

By: 
Thomas J. McGuire, Secretary

Date: 7/16/08

UNITED HEALTHCARE OF NORTH CAROLINA, INC.

By: 
Austin Pittman, CEO

Date: 7-14-08

EXHIBIT A
Multistate Areas of Review

- A. Claim(s): The UHC Companies shall ensure that claim(s) are investigated and paid, denied or contested within the required timeframes, that claim(s)-related correspondence is completed within the required timeframes, that claim(s) are paid correctly and interest is paid when required, that payments are made at the correct rate, that providers and covered persons are given an opportunity to provide missing information that is needed to process claim(s) before closing claim(s), that claim(s) files contain all necessary documentation, that explanatory information provided to insureds, enrollees, and providers is accurate and complete and contains all required information and that claim(s) personnel shall be properly trained in these duties.
- B. Coordination of Benefits: The UHC Companies shall ensure that the coordination of benefits rules, policies and procedures are consistently followed and to ensure claim(s) are paid correctly under the coordination of benefits rules.
- C. Appeals, Grievances and Complaints: The UHC Companies shall ensure that provider, insured and enrollee appeals, grievances and complaints are being addressed timely, efficiently, and thoroughly; that proper and accurate explanations and information are provided; that the appeals, grievances, complaints and all related matters are conducted within required timeframes; and that complaint registers are properly maintained.
- D. Explanation of Benefits: The UHC Companies shall ensure that the information contained in EOBs is accurate and complete.
- E. Contracted Entities: The UHC Companies shall ensure adequate oversight over vendors, service providers, and other companies that provide insurance-related-services for the UHC Companies, including but not limited to United Behavioral Health ("UBH"); that contracts with

third party administrators, intermediaries, utilization review agents, participating providers, and other service providers and vendors follow the law in their form, substance, and filing requirements; that the financial accounting of related contracted entities is accurate and complete; that such vendors hold all necessary licenses and otherwise comply with all legal requirements; and that contracted entities do not have impermissible conflicts of interest, particularly with respect to entities that adjust and settle claim(s) on behalf of the UHC Companies.

F. Utilization Review: The UHC Companies shall ensure that the handling of utilization review determinations are done in accordance with the statutes and regulations.

G. Operations/Management: The UHC Companies shall ensure that there is a formal structure to address state regulatory concerns, and that their responses to regulator, provider, insured, and enrollee inquiries, issues, and concerns are complete, accurate and timely.

H. Provider Network: The UHC Companies shall maintain accurate, complete and up-to-date list of in-network providers and to ensure that the provider network is adequate. Accurate provider lists shall be made available to subscribers.

EXHIBIT B
Process Improvement Plan

FUNCTION/ IMPROVEMENT OPPORTUNITY	DESCRIPTION	ACTION ITEMS
Section I:	Claim(s) Accuracy and Timeliness	
A. Claim(s) Timeframes and Interest Management	Management of the interest payment process for claim(s) that are paid outside of regulated guidelines.	<ul style="list-style-type: none"> •Increased automation of interest calculations on original claim(s) paid outside regulated timeframes. •Claim(s) job aides deployed and enhanced to enable processors to determine interest payments on claim(s) adjustments or repays.
B. Claim(s) lifecycle Management	Continued improvements to the overall claim(s) tracking lifecycle.	<ul style="list-style-type: none"> •Complete a detailed review of the control points throughout the claim(s) payment process. •Identify opportunities to further tighten controls within the beginning and end points.
C. Claim(s) Payment Quality Programs	Conduct claim(s) validation reviews focused on performance, customer-specific, high dollar and audit results to drive continuous quality improvement standards and defect reduction.	<ul style="list-style-type: none"> •Analyze top defect categories and determine remediation plans specific to root cause of errors. •Execute on remediation plans (including systems enhancements) to bring financial accuracy rating up to targeted levels. •Measure claim(s) accuracy on a DAR metric.
D. Improvements to Overall Claim(s) Processing	<ul style="list-style-type: none"> •Implement and continue to enhance COMET claim(s) adjudication tool. •Manage post adjudication tool to redirect high risk claim(s) for additional manual review. 	<ul style="list-style-type: none"> •Deploy and enhance sophisticated claim(s) engine rules that further automates claim(s) processing. •Implement a graphic user interface processing tool which provides enhanced processing instructions and

		improves the overall ease to process claim(s).
E. Contract Loading Timely and accurate loading reduces downstream claim(s) payment errors	Quality Programs - Drive remediation, improve quality assurance of contract loading process. Drive standardized process for submission, loading, testing and quality review of network provider contracts.	•Drive process whereby facility and provide schedules are loaded and tested prior to effective date.
F. Retroactively Effective Contracts/Amendments Implementing controls around submission positively impacts downstream claim(s) issues.	Management approval process designed to significantly reduce number of retroactively loaded contracts. Enhance controls and policies and procedures to manage retroactive contracting and to proactively adjust claim(s).	•Streamline physician contract submission process. •Management review/oversight of retroactivity results. •Technology enhancement to route retroactive submissions with claim(s) impact to regional management for approval.
G. Non-standard Contract Provisions Remediate to standard provisions for faster and more accurate claim(s) adjudication	Implement process to track, monitor and report adherence to standard contract protocols and resolve non-standard provisions at renewal.	•Performance metrics for each market are reviewed to assess remediation needs.
Section II:	Coordination of Benefits	
A. Improvements to the process to improve COB Primacy data and reduce adjustments	COB proactive outreach process - designed to identify all members with other insurance COB surveys targeted to improve other insurance information in multi-dependent families.	•Employ claim(s) data file comparison algorithms across Company to identify members that would be likely to have other insurance. •Proactive outreach and verification to membership with real time COB updates to systems. Surveys sent to multi-dependent families to determine other coverage information.
B. Technology Improvements	Implement CMS data exchange program.	•Manage data exchange program with Medicare to identify Medicare Primacy and automatically upload data into Company systems.

Section III:	Appeals, Grievances & Complaints	
A. Alignment of Consumer and Provider Appeals, Grievance and Complaint Handling Improve quality and timeliness of escalation processes	<ul style="list-style-type: none"> Member and provider appeals processing consolidation into a single organization to ensure consistent processing, eliminate routing delays and improve inventory tracking. 	<ul style="list-style-type: none"> Creation of a Infrastructure/Policy/Controls (IPC) team responsible for the development and implementation of standard processes consistent with regulatory requirements. Complete implementation of a single database to process and track complaints. Improve letter template functionality (Client Letter) and quality review programs.
B. Provider Issue Resolution	Enhanced provider call process designed to increase first call resolution and improve the overall call center experience for providers. Program utilizes one level for initial claim(s) related call with second level handling of complex and escalated issues.	<ul style="list-style-type: none"> Roll out schedule by state and capacity Survey providers for process Feedback improvement
C. Provider Outreach	Provider Complaint Follow-up Program targeted to network providers with high volume complaints and/or issues. Facilitate communication with providers and address both root cause and relationship issues resulting from continued non-resolution.	<ul style="list-style-type: none"> Data mining to determine high volume providers by state Root cause analyses to determine best resolution paths Outreach to providers to resolve issues. Tracking and trending of data. Distill and disseminate to senior management for further remediation.
Section IV:	Explanation of Benefits	
A. Development of Statements to Enhance Insured Experience	<p>Quality Reviews - Conduct EOB validation reviews focused on ensuring information contained on the EOB is complete and accurate and meet state requirements.</p> <p>Health Statements - Develop an all inclusive monthly statement to compliment the information that</p>	<ul style="list-style-type: none"> Review findings with management and develop remediation plans. Monitor and test remediation plans. Simplify communications to members by summarizing

	members currently receive.	account balances, deductibles, copays, and all processed claim(s) for the period. •Provides health care consumer alerts and affordability tips.
Section V:	Contracted Entities	
A. Oversight of Contract Entities	•Consolidation of recovery Vendors	Continued monitoring and assessment of recovery vendors - numbers and performance.
	•Enhanced review of material delegates to determine additional oversight opportunities	•Complete a review of delegated oversight activities performed by the business. •Develop remediation plans for identified improvement opportunities. •Redesign workflows and procedures for filings.
Section VI:	Utilization Review	
A. Utilization Review	Ongoing process to review, update and document state	Review of current P&Ps to ensure compliance with state
Determination	specific utilization review related	requirements.
Processing	compliance requirements. Manual letter review update to ensure letter content compliance.	Conduct ongoing monitoring
Ensure the handling of utilization review	Monitoring to identify and remediate operational defects including upstream operational	activities with feedback to impacted operational areas, including:
determinations is done in accordance with the Law	issues that may impact overall compliance.	•Performance of periodic random quality assessments to determine accuracy, letter quality, timeliness and compliance with regulatory requirements. •Focused reviews of state specific compliance issues, regulatory CAP requirements and known defect areas. •Review upstream operational issues to ensure that all claim(s) requiring clinical review

		are directed to the appropriate clinical areas on a timely basis. •Deliver ongoing training and education
Section VII:	Operations/Management	
A. Oversight Process and Scorecards Promotes greater coordination and resolution across business units Further empowers local management to assess and address operational performance	Oversight Process - process to manage all operational and system issues contributing to member, provider and DOI/regulatory service experience. Process includes meetings with local management to review state and national service trends and local health plan issues as well as meetings with a national committee that includes executives from key operational units focused on providing updates on critical operational improvements and initiatives, creating feedback loops and providing a mechanism and resources for root cause analysis. Scorecards -state-specific scorecards to capture key operational data, including data on provider networks, claim(s) processing, call service and complaint handling. Reviewed by local and corporate management, regulatory affairs, compliance, and national committee to assess performance against statutory requirements, internal goals and to identify and resolve root cause and organizational performance issues.	•Establish oversight committee process. •Conduct regular meetings to review and address data, local management identified issues, and assess status of remediation on previously identified issues. Recommend improvements, make assignments and establish due dates for completion. •Develop state-specific scorecards. •Develop template for reporting results of service improvements to regulators for relevant markets.
B. New Regulatory Affairs and National Compliance	Create new Regulatory Affairs and National Compliance organizations to better support	•Integrate Regulatory Affairs teams across all commercial businesses.

<p>Organizations Make UnitedHealthcare smaller, simpler to understand and easier to navigate</p>	<p>and enhance our regulatory relationships, make it easier to navigate between internal business units and advance our efforts to improve healthcare affordability, accessibility, quality and simplicity.</p>	<ul style="list-style-type: none"> •Deploy state by state regulatory account management structure. •Establish specific Regulatory Affairs and Governmental Affairs plans on a state by state basis. •Ensure that regulators are timely informed on affordability and health care transformation initiatives.
<p>Section VIII:</p>	<p>Provider Network</p>	
<p>A. Provider Directories Provide uniform and accurate provider listings to members across all markets, all products</p>	<p>Improved Data Integrity - implement a relational database improving data integrity by automatically updating linked provider records. Created Provider Data Integrity Team to address provider data quality issues. Manual cleanup and ongoing quality review developed. Assessing additional system enhancement needed to address information gaps and bring all data into a single point of ingress/egress.</p>	<ul style="list-style-type: none"> •Established delegated provider process to get full roster updates once per year plus. monthly / quarterly updates. •For non-delegated providers established outreach phone calls and follow up activities for updated information.

EXHIBIT C
Benchmarks

A. Definitions –

For purposes of this Exhibit, the following definitions shall apply.

1. "Claim(s) Accuracy" shall mean the measure as defined and reported in the 2007 Multistate Agreement, and as defined and reported in NCDOI Attachment 1.
 2. "Claim(s) Timeliness" shall mean the measure as defined in and reported pursuant to the Multistate Agreement, and as defined and reported in NCDOI Attachment 1.
 3. "Appeals: Non-clinical" shall mean the measure as defined in and reported pursuant to the Multistate Agreement, and as defined and reported in NCDOI Attachment 1.
 4. "Appeals: Clinical" shall mean the measure as defined in and reported pursuant to the 2007 Multistate Agreement, and as defined and reported in NCDOI Attachment 1.
 5. "DOI Complaints" shall mean the measure as defined in and reported pursuant to the Multistate Agreement, and as defined and reported in NCDOI Attachment 1.
- B. Performance standards – (also referred to herein as “tolerance standards”)

For the calendar year 2008, the UHC Companies and the Signatory Regulators agree:

- a. That the UHC Companies shall meet the 2008 tolerance standard for Claim(s) Accuracy of 96%.
- b. That the UHC Companies shall meet the 2008 tolerance standard for Claim(s) Timeliness of 94%.
- c. That the UHC Companies shall meet the 2008 tolerance standard for Appeals: Non-clinical of 93%.

- d. That the UHC Companies shall meet the 2008 tolerance standard for Appeals: Clinical of 97%.
 - e. That the UHC Companies shall meet the 2008 tolerance standard for DOI Complaints of 35%.
2. For the calendar year 2009, the UHC Companies and the Signatory Regulators agree:
- a. That the UHC Companies shall meet the 2009 tolerance standard for Claim(s) Accuracy of 97%.
 - b. That the UHC Companies shall meet the 2009 tolerance standards for Claim(s) Timeliness of 95%.
 - c. That the UHC Companies shall meet the 2009 tolerance standard for Appeals; Non-clinical of 94%.
 - d. That the UHC Companies shall meet the 2009 tolerance standard for Appeals: Clinical of 97%.
 - e. That the UHC Companies fail to meet the 2009 tolerance standard for DOI Complaints of 34%.
3. For the calendar year 2010, the UHC Companies and the Signatory Regulators agree:
- a. That the UHC Companies shall meet the 2010 tolerance standard for Claim(s) Accuracy of 97%.
 - b. That the UHC Companies shall meet the 2010 tolerance standard for Claim(s) Timeliness of 96%.
 - c. That the UHC Companies shall meet the 2010 tolerance standard for Appeals: Non-clinical of 95%.
 - d. That the UHC Companies shall meet the 2010 tolerance standard for Appeals: Clinical of 97%.

e. That the UHC Companies shall meet the 2010 tolerance standard for DOI Complaints of 33%.

C. Other Provisions -

1. In determining the UHC Companies' performance with respect to any of the tolerance standards set forth in Paragraph B. above, the result will be determined by totaling the UHC Companies' results for the four quarters for the relevant calendar year divided by four. For purposes of assessing the UHC Companies' performance with respect to any of the Claim(s) Accuracy, UHC Claim(s) Timeliness, Appeals: Non-clinical, and Appeals: Clinical tolerance standards all results will be rounded up to the next tenth percentile, and with respect to the DOI Complaints standard, rounded down to the next tenth percentile. The tolerance standards set forth in Paragraph B. above will be measured using aggregate national data and based on the definitions set forth in NCDOI Attachment 1.

EXHIBIT D

Required Reports and Monitoring

1. Reports

The UHC Companies shall provide quarterly reports to the Lead Regulators as follows:

- a. National and jurisdiction specific internal complaints data from insureds, enrollees, providers, and Regulators by complaint category, consistent with NAIC data base coding.
- b. National and jurisdiction specific claim(s)s processing timeliness as defined in the Benchmarks.
- c. National and jurisdiction specific claim(s)s processing accuracy rates as defined in the Benchmarks.
- d. National and jurisdiction specific data relating to reviews relating to compliance with coordination of benefits rules.
- e. National and jurisdiction specific data relating to appeals, grievances and complaints.
- f. Jurisdiction specific data relating to reviews relating to the accuracy and completeness of explanations of benefits.
- g. Reviews of arrangements with and the activities of third party vendors, service providers, and other companies providing insurance-related services for the UHC Companies.
- h. National and jurisdiction specific data relating to reviews of utilization determinations for compliance with applicable law.
- i. National and jurisdiction specific data relating to reviews relating to the accuracy of information provided regarding in-network providers.
- j. Written reports of the Annual Compliance Reviews.

k. Progress reports on the addition of affiliates of the UHC Companies to the UHC Platform as they occur.

l. Progress reports describing specific operational or procedural changes implemented under the process improvement plan and their actual / expected impact on areas of concern.

m. National and jurisdiction specific revisions or adjustments to the Process Improvement Plan and impacted Multistate Areas of Review as they occur.

n. National and jurisdiction specific data relating to restitution efforts made during the Term. This includes number of claim(s) and dollar impact of claim(s) reprocessed and paid under items a. - i., above (details for each item).

2. Certification

All reports containing national data shall be certified in accordance with the manner set forth in the Multistate Agreement.

EXHIBIT E

UnitedHealthcare of North Carolina, Inc. Areas of Review concerning the 2006 VSA

- A. **Sales and Marketing:** Such area of review shall not include any of the Multistate Areas of Review covered in Section(s) A through H to Exhibit A in this Agreement.
- B. **Premium Rate Setting and Underwriting:** Such area of review shall not include any of the Multistate Areas of Review covered in Section(s) A through H to Exhibit A in this Agreement.
- C. **Provider Credentialing:** Such area of review shall not include any of the Multistate Areas of Review covered in Section(s) A through H to Exhibit A in this Agreement.
- D. **General Administration:** Such area of review shall not include any of the Multistate Areas of Review covered in Section(s) A through H to Exhibit A in this Agreement.

CLAIMS VOLUME / ACCURACY			
Total number of claims processed: EDI			
Total number of claims processed: ED per 1,000 members			
Total number of claims processed: paper			
Total number of claims processed: paper per 1,000 members			
Total number of claims paid (includes 0 pay)			
Total number of claims denied			
Total number of claims adjusted			
Total number of claims adjusted per 1,000 members			
Rate: claim accuracy (paper)			
Rate: claim accuracy (EDI)			
CLAIMS TIMELINESS/INVENTORY			
Claim Timeliness			
Number of claims processed within 30 calendar days			
Rate: percent of claims processed within 30 calendar days			
Rate: percent of claims processed in excess of 30 calendar days (ED)			
Rate: percent of claims processed within 30 calendar days (paper)			
Rate: percent of claims processed within 30 calendar days (EDI)			
CLAIM INVENTORY			
Number of claims in excess of 40 business days (ED)			
Rate: percent of claims in excess of 40 business days (ED)			
Rate: percent of claims in excess of 40 business days (EDI)			
Number of claims in excess of 30 to 40 business days (ED)			
Rate: percent of claims in excess of 30 to 40 business days (ED)			
Number of claims in excess of 30 to 40 business days (EDI)			
Rate: percent of claims in excess of 30 to 40 business days (EDI)			
Number of claims in excess of 20 business days (paper)			
Rate: percent of claims in excess of 20 business days (paper)			
Number of claims in excess of 20 business days (EDI)			
Rate: percent of claims in excess of 20 business days (EDI)			
PROVIDER CALL VOLUME (non claim-based)			
PROVIDER FIRST CALL RESOLUTION (claim based)			
Total number - resolved			
Total number of escalates: provider calls per 1,000 members			
Rate: first call resolution (non-escalation)			
Rate: first call resolution (escalation)			
APPEALS: Non-clinical (claim based)			
Total number received			
Total number addressed			
Total number of appeals for which additional information was received that resulted in reversal			
Total number addressed within 30 calendar days of receipt			
Rate: percent addressed within 30 calendar days of receipt			
Rate: percent overturned			
Rate: percent resolved on initial receipt			
APPEALS: Clinical (Claim-based)			
Total number received			
Total number addressed			
Total number of appeals for which additional information was received that resulted in reversal			
Total number addressed within 30 calendar days of receipt			
Rate: percent addressed within 30 calendar business days of receipt			
Rate: percent overturned			
Rate: percent resolved on initial receipt			
DOI COMPLAINTS			
Total number of complaints received			
Total number of complaints received per 1,000 members			
Total Complaints received per 1,000 Claims			
Total number of complaints for which additional information was received that resulted in reversal			
Total number of complaints addressed			
Number of complaints addressed within 30 calendar days of receipt			
Rate: percent overturned			
Rate: percent resolved			

Participating and nonparticipating provider status is determined at benefit level not contract level. Data is for participating legal entities and Commercial Insurance only, on UNET or COSMOS.

DEFINITIONS Reports should be supplied within 60 days of close of quarter

- A. Data is fully insured only. State data is based on state of residence of the insured.
1. The number of EDI claims processed within specified time period. Includes paid, denied and closed claims.
 2. Membership is based on the state of residence of the insured.
 3. The same as in A.1 but for paper claims.
 4. Membership is based on the state of residence of the insured.
 5. The number of claims processed within period includes all claims for which a payment was made and "zero pays" (any claim in which a payment was not made but applied to the insured's deductible, coinsurance).
 6. Number of claims for which the allowable expense was zero within the period.
 7. Number of claims previously paid for which an additional-changed payment was made within the period.
 8. Number equal to A.7 divided by members.
 9. Calculated based on the dollar accuracy rate. Total dollars corrected/dollars paid.
 10. Number equal to A.1 plus A.3.
- B. Data is for fully insured only. State data is based on state of residence of the insured. Measurement is from time of receipt at United to time of EOB mailing.
1. Total number of claims processed (closed, denied, or paid) within specified time frame.
 2. Total number of claims processed within specified time frame/total number of claims processed in specified time period.
 3. The total number of claims (EDI received) processed within specified time frame (over thirty calendar days) divided by the number identified in A.1.
 4. The total number of claims (paper received) processed within specified time frame/the number identified in A.3.
- C. Data is fully insured only. State data is based on state of residence of insured. Measurement is from date of receipt at United or its contracted entity.
1. Number of claims received electronically that have not been processed within specified time frame.
 2. Same as C.1 but for different time period.
 3. Number of claims received electronically that have not been processed within time frame/total number of claims processed in time period. (number in A.1)
 4. Same as 3 except for specified time frame.
 5. Same as 1 except relates to claims received via paper.
 6. Same as 2 except relates to claims received via paper.
 7. Same as 3 except relates to claims received via paper and denominator is number in A.3.
 8. Same as 4 except relates to claims received via paper.
 9. Clean system days and inventory for each calendar date in time period/number of days in time period.
 10. Data is reported based on state of residence of the insured. Includes fully insured and ASO calls. Only non claim related calls.
- D. Data is reported based on state of residence of the insured. Includes fully insured and ASO calls. Only claim (post claim) related calls.
1. Total number of provider calls received in call service centers that are not claim based (e.g. eligibility).
 2. Total number of provider calls received in call service centers that are claim based.
 3. Total number of calls received in PCSU or its successor.
 4. Number of provider calls into call service centers that are repeat calls within 90 days of initial call/total number of provider calls into call centers.
 5. Number of calls into PCSU that are repeat calls within 90 day/total number of calls into PCSU.
- E. Data is reported for fully insured only. Includes all claim (post-claim) based appeals.
1. Total number (first and second level). Data is from PAO and NASC.
 2. Addressed = appeals that were processed and closed.
 3. Number of appeals reversed based on the submission of additional information.
 4. Total number of appeals processed and closed within specified time after receipt at United.
 5. Number referenced in F.3/total number of appeals received within that time period.
 6. Number of claim determinations reversed (not including those for which additional information submitted resulted in reversal)/total number of appeals addressed.
 7. Total number of second level appeals received/total number of all appeals received.
- F. Data is reported for fully insured only. Includes all clinical claim (post-claim) based appeals. Clinical is as defined by local state's requirement, or listing thereof, by United's standards.
1. Total number (first and second level). Data is from PAO and NASC.
 2. Addressed = appeals that were processed and closed.
 3. Number of appeals reversed based on the submission of additional information.
 4. Same as F.3 but for clinical appeals.
 5. Same as F.4 but for clinical appeals after receipt at United.
 6. Number of clinical appeals reversed (not including those in which additional information submitted resulted in reversal)/total number of appeals addressed.
 7. Total number of second level appeals received/total number of appeals received.
- G. Data is based on complaints received from State Insurance Department for which Department accepts jurisdiction. State data is based on state of submission.
1. Total number of complaints received at United within specified time period.
 2. Membership is based on the state of residence of the insured.
 3. Number equal to H-1 divided by A.10.
 4. Number of appeals/complaints based on the submission of additional information.
 5. Addressed = complaints that were processed and closed.
 6. The number processed and closed within specified time period.
 7. Number of complaints reversed (not including those for which additional information submitted resulted in reversal)/total number of complaints addressed.
 8. Number of complaints addressed for which the insurance department submitted additional preventable requests to the Company/number of complaints addressed.