

PARTICIPATING REGULATOR ADOPTION

On behalf of the Kentucky Office of Insurance, I, Julie Mix McPeak, Executive Director, hereby adopt, agree, and approve this Agreement between the Lead Regulators, Participating Regulators, and the UHC Companies.

KENTUCKY OFFICE OF INSURANCE

BY: Julie Mix McPeak
Julie Mix McPeak
Executive Director
July _____, 2007
August 17, 2007

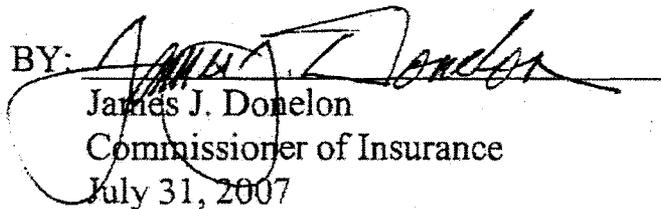
**IN THE MATTER OF
UNITED HEALTHCARE INSURANCE COMPANY, ETAL.
REGULATORY SETTLEMENT AGREEMENT**

PARTICIPATING REGULATOR ADOPTION

On behalf of the Louisiana Insurance Department, I, James J. Donelon, Commissioner of Insurance, hereby adopt, agree and approve this Regulatory Settlement Agreement, including the monetary assessment set forth in paragraph B.3.

LOUISIANA DEPARTMENT OF INSURANCE

BY:



James J. Donelon
Commissioner of Insurance
July 31, 2007

PARTICIPATING REGULATOR ADOPTION

On behalf of the State of Michigan, Office of Financial and Insurance Services, I, Linda

A. Watters, hereby adopt, agree, and approve this Agreement.

OFFICE OF FINANCIAL AND INSURANCE SERVICES

BY:

Linda A. Watters

Linda A. Watters
Commissioner

DATE:

8-21-07

PARTICIPATING REGULATOR ADOPTION

On behalf the Minnesota Department of Commerce, I, Pat Nelson, hereby adopt, agree,
and approve this Agreement.

MINNESOTA DEPARTMENT OF COMMERCE

BY: 

PATRICK NELSON
Deputy Commissioner
Market Assurance
85 Seventh Place East, Suite 500
St. Paul, Minnesota 55101
Telephone: (651)296-2488

PARTICIPATING REGULATOR ADOPTION

On behalf of the State of Montana and the Department of Insurance of the Montana State Auditor's Office, I, Janice S. VanRiper, Deputy Insurance Commissioner, hereby adopt, agree and approve this Agreement.

Montana State Auditor's Office

By: 
JANICE S. VANRIPER
Deputy Insurance Commissioner

Date: August 15, 2007

PARICIPATING REGULATOR ADOPTION

On behalf of the Nebraska Department of Insurance, I, L. Tim Wagner, hereby adopt,
Agree, and approve this Agreement except for the Monetary Assessment set forth in
Paragraph B.3.

NEBRASKA DEPARTMENT OF INSURANCE

BY:  _____

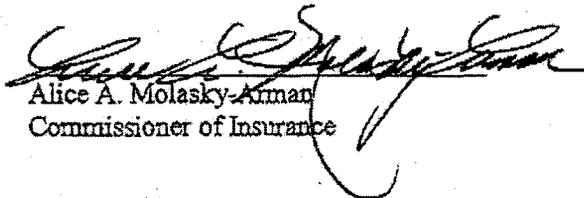
L. Tim Wagner
Director
Nebraska Department of Insurance
July 5, 2007

PARTICIPATING REGULATOR ADOPTION

On behalf of the State of Nevada, Department of Business and Industry, Division of Insurance, I, Alice A. Molasky-Arman, Commissioner of Insurance, hereby adopt, agree, and approve this Agreement.

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

BY:


Alice A. Molasky-Arman
Commissioner of Insurance

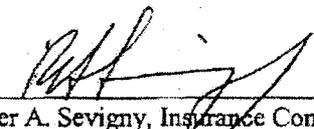
DATED: This 17th day of August, 2007.

TIME: 4:55 a.m. p.m.

PARTICIPATING REGULATOR ADOPTION

On behalf of the New Hampshire Insurance Department I, Roger A. Sevigny, hereby adopt, agree,
and approve this Agreement.

NEW HAMPSHIRE INSURANCE DEPARTMENT

BY: 

Roger A. Sevigny, Insurance Commissioner
August 17, 2007

PARTICIPATING REGULATOR ADOPTION

On behalf of the State of New Mexico Public Regulation Commission Insurance
Division, I, Morris J. Chavez, hereby adopt, agree and approve this Agreement.

NEW MEXICO PUBLIC REGULATION COMMISSION
INSURANCE DIVISION

BY: M J Chavez
Morris J. Chavez, Superintendent of Insurance

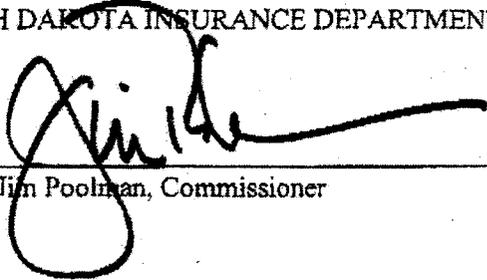
DATE: 8/27/07

PARTICIPATING REGULATOR ADOPTION

On behalf of the North Dakota Insurance Department, I, Commissioner Jim Poolman, hereby adopt, agree, and approve this Agreement.

NORTH DAKOTA INSURANCE DEPARTMENT

BY:



Jim Poolman, Commissioner

8/1/07

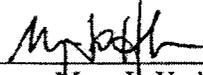
Date

PARTICIPATING REGULATOR ADOPTION

On behalf of the State of Ohio, the Ohio Department of Insurance, I, Mary Jo Hudson,
Superintendent of Insurance, hereby adopt, agree, and approve this Agreement.

OHIO DEPARTMENT OF INSURANCE

BY: _____



Mary Jo Hudson
Superintendent

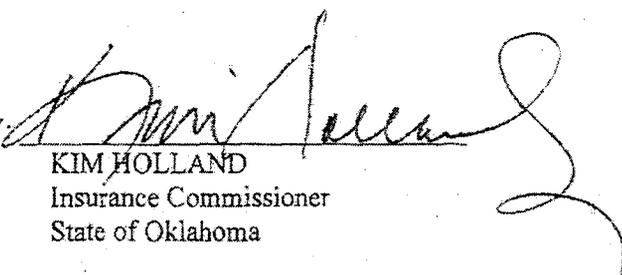
DATE: _____

10 July 2007

PARTICIPATING REGULATORY ADOPTION
(Oklahoma Case Number 07-~~0915~~-DIS)

On behalf of the Insurance Department of the State of Oklahoma, I, Kim Holland, hereby adopt,
agree, and approve this Agreement.

OKLAHOMA INSURANCE DEPARTMENT

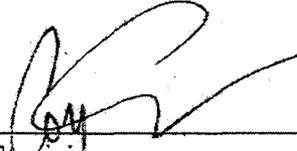
BY: 
KIM HOLLAND
Insurance Commissioner
State of Oklahoma

DATE: July 25, 2007

PARTICIPATING REGULATOR ADOPTION

On behalf the Oregon Department of Consumer and Business Services, I, Cory Streisinger, hereby adopt, agree, and approve this Agreement.

Dated AUG 28 2007



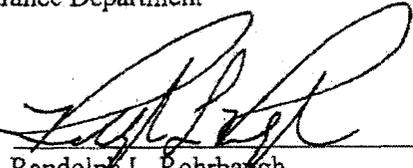
Cory Streisinger
Director
Department of Consumer and Business Services

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PARTICIPATING REGULATOR ADOPTION

On behalf of the Commonwealth of Pennsylvania, I, Randolph L. Rohrbaugh, Deputy
Insurance Commissioner, hereby adopt, agree and approve this Agreement.

COMMONWEALTH OF PENNSYLVANIA
Insurance Department

By: 

Randolph L. Rohrbaugh
Deputy Insurance Commissioner

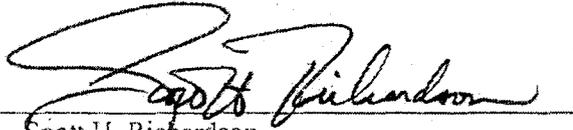
Date: *8/16/07*

PARTICIPATING REGULATOR ADOPTION

On behalf of the South Carolina Department of Insurance, I, Scott H. Richardson, hereby
adopt, agree, and approve this agreement.

SOUTH CAROLINA DEPARTMENT OF INSURANCE

BY:

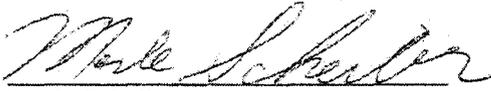


Scott H. Richardson
Director

August 12, 2007

PARTICIPATING REGULATOR ADOPTION

On behalf of the South Dakota Department of Revenue and Regulation, Division of Insurance, I, Merle Scheiber, Director of the South Dakota Division of Insurance, hereby adopt, agree, and approve this Agreement.

 JULY 23, 2007

Merle Scheiber, Director
South Dakota Division of Insurance

PARTICIPATING REGULATOR ADOPTION

On behalf of the Tennessee Department of Commerce and Insurance, I, Leslie A. Newman, hereby adopt, agree and approve this Agreement.

TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

BY: Leslie A. Newman

DATE: 8-21-07

Leslie A. Newman, Commissioner

IN THE MATTER OF
UNITEDHEALTHCARE INSURANCE COMPANY, ET AL.
REGULATORY SETTLEMENT AGREEMENT

PARTICIPATING REGULATOR ADOPTION

On behalf of the State of Utah and the Utah Insurance Department, I, D. Kent
Michie, Commissioner, hereby adopt, agree, and approve this Agreement.

Utah Insurance Department

BY: D. Kent Michie
D. Kent Michie
Commissioner

DATE: 06-25-07

Confidential Document

PARTICIPATING REGULATOR ADOPTION

On behalf of The State of Vermont Department of Banking, Insurance, Securities and Health Care Administration, I, Paulette J. Thabault, Commissioner, hereby adopt, agree, and approve this Agreement.

VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

BY: Paulette J. Thabault
Paulette J. Thabault, Commissioner

8/30/07
Date

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

070810281

AT RICHMOND, AUGUST 9, 2007

UNITEDHEALTHCARE INSURANCE COMPANY, et al.

CASE NO. INS-2007-00221

Ex Parte: In the matter of Approval of a Multi-State Regulatory Settlement Agreement between UnitedHealthcare Insurance Company, et al., and the Arkansas Department of Insurance, the Connecticut Department of Insurance, the Florida Office of Insurance Regulation, the Iowa Insurance Division, and the New York State Insurance Department, for and on behalf of the Virginia Bureau of Insurance and the Insurance Regulators of the all remaining States and the District of Columbia.

2007 AUG -9 P 12:53

DOCUMENT CONTROL

ORDER APPROVING SETTLEMENT AGREEMENT

ON THIS DAY came the Bureau of Insurance ("the Bureau"), by counsel, and requested (i) Commission approval and acceptance of a multi-state Regulatory Settlement Agreement ("the Agreement"), a copy of which is attached hereto and made a part hereof, by and between the Commissioners of Insurance for the States of Arkansas, Connecticut, Florida and Iowa and the Superintendent of Insurance for the State of New York, and UnitedHealthcare Insurance Company, et al., (collectively, the "Company"), domiciled in Connecticut and licensed to transact the business of insurance in the Commonwealth of Virginia, and (ii) authority to execute any documents attendant to the Agreement necessary to evidence the Commission's acceptance of the Agreement;

NOW THE COMMISSION, having considered the terms of the Agreement together with the recommendation of the Bureau that the Commission approve and accept the Agreement, is of the opinion, finds, and ORDERS that

(1) The Agreement be, and it is hereby, APPROVED AND ACCEPTED and;

(2) The Commissioner of Insurance be, and he is hereby authorized to execute any attendant documents necessary to evidence the Commission's approval and acceptance of the Agreement.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:

Julie Benafield Bowman, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Eric R. Dinallo, Superintendent
New York State Insurance Department
25 Beaver St.
New York, NY 10004

Thomas R. Sullivan, Commissioner
State of Connecticut
Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

Forrest G. Burke
General Counsel
UnitedHealthcare Insurance Company
5901 Lincoln Dr., MN012-N205
Edina, MN 55436

Kevin M. McCarty, Commissioner
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399-0305

Nicholas Thompson
Mitchell, Williams, Selig, Gates, Woodyard,
PLLC
425 West Capitol Ave., Ste 1800
Little Rock, Arkansas 72201-3525

Susan E. Voss, Commissioner
Iowa Insurance Division
330 Maple St.
Des Moines, IA 50319-0065

Jacqueline K. Cunningham
Deputy Commissioner
Bureau of Insurance
State Corporation Commission
1300 East Main Street
Richmond, Virginia 23219

A True Copy
Teste:


Clerk of the
State Corporation Commission

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

IN THE MATTER OF:

UnitedHealthcare Insurance Company, et al.

CASE NO. INS-2007-00221

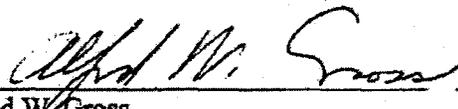
PARTICIPATING REGULATOR ADOPTION

ON THIS DAY this matter came before the Virginia Bureau of Insurance, State Corporation Commission (the "Bureau") for consideration, and, upon consideration thereof, the Commissioner of Insurance finds:

1. UnitedHealthcare Insurance Company, and its affiliate UnitedHealthcare of the Mid-Atlantic, Inc., (collectively, the "Company") are licensed to transact the business of insurance in the Commonwealth of Virginia. As affecting the Commonwealth of Virginia, the Bureau has jurisdiction over the subject matter of this proceeding and the Company;
2. In December 2004, certain regulators facilitated by the National Association of Insurance Commissioners began a multi-state analysis the UnitedHealthcare companies. The analysis focused on Company compliance with certain insurance and health maintenance organization laws, including those in the Commonwealth of Virginia;
3. A settlement has been presented to the Bureau, the terms of which are set forth in a Regulatory Settlement Agreement ("Agreement") which has been signed by the Company and the Commissioners of Insurance for the States of Arkansas, Connecticut, Florida and Iowa and the Superintendent of Insurance for the State of New York, (collectively, the "Lead Regulators"). The Company understands that it has a right to a hearing in this matter, and has agreed to waive such rights, in accordance with the Agreement.
4. The Bureau expressly adopts, agrees and approves this Agreement as a fair and proper disposition of the matters addressed herein.

A COPY hereof shall be filed with the Clerk of the Commission and thereby placed in

Case No. INS-2007-00221.



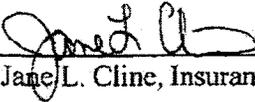
Alfred W. Gross,
Commissioner of Insurance
Bureau of Insurance
State Corporation Commission
Commonwealth of Virginia

AUG 7,
2007
Date

PARTICIPATING REGULATORY ADOPTION

On behalf of the State of West Virginia, I, Jane L. Cline, Insurance Commissioner,
hereby adopt, agree, and approve this Agreement.

OFFICES OF THE INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA

BY:  7/11/07
Jane L. Cline, Insurance Commissioner Date

PARTICIPATING REGULATOR ADOPTION

On behalf of the Wyoming Department of Insurance, I, Kenneth G. Vines, Commissioner,
hereby adopt, agree and approve this Agreement.

WYOMING DEPARTMENT OF INSURANCE

BY: *Kenneth G. Vines*
Kenneth G. Vines
Insurance Commissioner

Date: August 20, 2007

EXHIBIT A

Multistate Areas of Review

- A. **Claims:** The UHC Companies shall ensure that claims are investigated and paid, denied or contested within the required timeframes, that claims-related correspondence is completed within the required timeframes, that claims 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 claims before closing claims, that claim 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 claims 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 claims 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 claims 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

Monetary Assessment and Schedule of Payments

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

1. Monetary Assessment shall be the sums referenced in paragraph B.3 of this Agreement.
2. Per Capita Assessment shall mean \$3.30725, an amount determined by dividing \$20,00,005.35 by 6,047,322 (representing the Commercial Insurance membership for the UHC Companies as of February 1, 2007 for all jurisdictions).

B. Monetary Assessment.

1. Any Monetary Assessment due to a Signatory Regulator agreeing to participate in the Monetary Assessment as reflected in Paragraph C, Column (4) below, will be determined by multiplying the Per Capita Assessment by the Signatory Regulator's membership as of February 1, 2007, as reflected in Paragraph C, Column (2) below.
2. The Signatory Regulator's applicable membership as of February 1, 2007 will be determined by the UHC Companies and supplied to the Lead Regulators within sixty (60) days of the Effective Date.

C. Table of Signatory Regulators

(1) Jurisdiction	(2) Membership	(3) % of Total	(4) Paragraph B.3 of the Agreement Participation	(5) Character of B.3 Participation
Total Jurisdictions			(Yes/No)	

(Assessment/Costs)

EXHIBIT C

Process Improvement Plan

FUNCTION/ IMPROVEMENT OPPORTUNITY	DESCRIPTION	ACTION ITEMS
Section I:	Claims Accuracy and Timeliness	
A. Claims Timeframes and Interest Management	Management of the interest payment process for claims that are paid outside of regulated guidelines.	<ul style="list-style-type: none"> • Increased automation of interest calculations on original claims paid outside regulated timeframes. • Claims job aides deployed and enhanced to enable processors to determine interest payments on claims adjustments or repays.
B. Claims lifecycle management	Continued improvements to the overall claims tracking lifecycle.	<ul style="list-style-type: none"> • Complete a detailed review of the control points throughout the claims payment process. • Identify opportunities to further tighten controls within the beginning and end points.
C. Claims Payment Quality Programs	Conduct claim 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 claims accuracy on a DAR metric.
D. Improvements to Overall Claims Processing	<ul style="list-style-type: none"> • Implement and continue to enhance COMET claims adjudication tool. • Manage post adjudication tool to redirect high risk claims for additional manual review. 	<ul style="list-style-type: none"> • Deploy and enhance sophisticated claims engine rules that further automates claims processing. • Implement a graphic user interface processing tool which provides enhanced processing instructions and

		improves the overall ease to process claims.
E. Contract Loading <i>Timely and accurate loading reduces downstream claim payment errors</i>	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.	<ul style="list-style-type: none"> • Drive process whereby facility and provide schedules are loaded and tested prior to effective date.
F. Retroactively Effective Contracts/Amendments <i>Implementing controls around submission positively impacts downstream claim issues.</i>	<p>Management approval process designed to significantly reduce number of retroactively loaded contracts.</p> <p>Enhance controls and policies and procedures to manage retroactive contracting and to proactively adjust claims.</p>	<ul style="list-style-type: none"> • Streamline physician contract submission process. • Management review/oversight of retroactivity results. • Technology enhancement to route retroactive submissions with claims impact to regional management for approval.
G. Non-standard Contract Provisions <i>Remediate to standard provisions for faster and more accurate claim adjudication</i>	Implement process to track, monitor and report adherence to standard contract protocols and resolve non-standard provisions at renewal.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Employ claim 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.
	COB surveys targeted to improve other insurance information in multi-dependent families.	Surveys sent to multi-dependent families to determine other coverage information.
B. Technology Improvements	Implement CMS data exchange program.	<ul style="list-style-type: none"> • Manage data exchange program with Medicare to identify Medicare Primacy and automatically upload data into Company systems.

Section III:	Appeals, Grievances & Complaints	
<p>A. Alignment of Consumer and Provider Appeals, Grievance and Complaint Handling</p> <p><i>Improve quality and timeliness of escalation processes</i></p>	<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.
<p>B. Provider Issue Resolution</p>	<p>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 related call with second level handling of complex and escalated issues.</p>	<ul style="list-style-type: none"> • Roll out schedule by state and capacity • Survey providers for process feedback/improvement
<p>C. Provider Outreach</p>	<p>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.</p>	<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	
<p>A. Development of Statements to Enhance Insured Experience</p>	<p>Quality Reviews - Conduct EOB validation reviews focused on ensuring information contained on the EOB is complete and accurate and meet state requirements.</p>	<ul style="list-style-type: none"> • Review findings with management and develop remediation plans. • Monitor and test remediation plans.
	<p>Health Statements - Develop an all inclusive monthly statement to compliment the information that</p>	<ul style="list-style-type: none"> • Simplify communications to members by summarizing

	members currently receive.	<p>account balances, deductibles, copays, and all processed claims for the period.</p> <ul style="list-style-type: none"> • Provides health care consumer alerts and affordability tips.
Section V:	Contracted Entities	
A. Oversight of Contract Entities	<ul style="list-style-type: none"> • Consolidation of recovery vendors 	<ul style="list-style-type: none"> • Continued monitoring and assessment of recovery vendors – numbers and performance.
	<ul style="list-style-type: none"> • Enhanced review of material delegates to determine additional oversight opportunities 	<ul style="list-style-type: none"> • 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	
<p>A. Utilization Review Determination Processing</p> <p><i>Ensure the handling of utilization review determinations is done in accordance with the law</i></p>	<p>Ongoing process to review, update and document state specific utilization review related compliance requirements. Manual letter review update to ensure letter content compliance. Monitoring to identify and remediate operational defects including upstream operational issues that may impact overall compliance.</p>	<p>Review of current P&Ps to ensure compliance with state requirements.</p> <p>Conduct ongoing monitoring activities with feedback to impacted operational areas, including:</p> <ul style="list-style-type: none"> • 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 claims requiring clinical review

		<p>are directed to the appropriate clinical areas on a timely basis.</p> <ul style="list-style-type: none"> • Deliver ongoing training and education
Section VII:	Operations/Management	
<p>A. Oversight Process and Scorecards</p> <p><i>Promotes greater coordination and resolution across business units</i></p> <p><i>Further empowers local management to assess and address operational performance</i></p>	<p>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.</p>	<ul style="list-style-type: none"> • 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.
	<p>Scorecards –state-specific scorecards to capture key operational data, including data on provider networks, claims 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.</p>	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Integrate Regulatory Affairs teams across all commercial businesses.

<p>Organizations</p> <p><i>Make UnitedHealthcare smaller, simpler to understand and easier to navigate</i></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: Provider Network</p>		
<p>A. Provider Directories</p> <p><i>Provide uniform and accurate provider listings to members across all markets, all products</i></p>	<p>Improved Data Integrity - implement a relational database improving data integrity by automatically updating linked provider records.</p> <p>Created Provider Data Integrity Team to address provider data quality issues. Manual cleanup and ongoing quality review developed.</p> <p>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 D Benchmarks

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

1. "Claims Accuracy" shall mean the measure as defined and reported in Attachment I, Section A.9., to this Exhibit.
2. "Claim Timeliness" shall mean the measure as defined in and reported pursuant to Attachment I. Section B.2., to this Exhibit.
3. "Appeals: Non-clinical" shall mean the measure as defined in and reported pursuant to Attachment I. Section F.5., to this Exhibit.
4. "Appeals: Clinical" shall mean the measure as defined in and reported pursuant to Attachment I. Section G.5., to this Exhibit.
5. "DOI Complaints" shall mean the measure as defined in and reported pursuant to Attachment I. Section H.7., to this Exhibit.
6. "Total Performance Assessment" shall mean the Per Capita Assessment, as set forth in Exhibit B, paragraph A.2, multiplied by the total Signatory Regulator membership as set forth in Table C, Column (2), of Exhibit B.

B. Performance Assessments.

1. For the calendar year 2008, the UHC Companies and the Signatory Regulators agree:
 - a. In the event that the UHC Companies fail to meet the 2008 tolerance standard for Claim Accuracy of 96%, the UHC Companies shall pay

to the Signatory Regulators the total sum equal to 5% of the Total Performance Assessment.

- b. In the event that the UHC Companies fail to meet the 2008 tolerance standard for Claim Timeliness of 94%, the UHC Companies shall pay to the Signatory Regulators the total sum equal to 5% of the Total Performance Assessment.
- c. In the event that the UHC Companies fail to meet the 2008 tolerance standard for Appeals: Non-clinical of 93%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 4% of the Total Performance Assessment.
- d. In the event that the UHC Companies fail to meet the 2008 tolerance standard for Appeals: Clinical of 97%, the UHC Companies shall pay to the Signatory Regulators the total sum equal to 4% of the Total Performance Assessment.
- e. In the event that the UHC Companies fail to meet the 2008 tolerance standard for DOI Complaints of 35%, the UHC Companies shall pay to the Signatory Regulators the total sum equal to 2% of the Total Performance Assessment.

2. For the calendar year 2009, the UHC Companies and the Signatory Regulators agree:

- a. In the event that the UHC Companies fail to meet the 2009 tolerance standard for Claim Accuracy of 97%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 7.5% of the Total Performance Assessment.
- b. In the event that the UHC Companies fail to meet the 2009 tolerance standards for Claim Timeliness of 95%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 7.5% of the Total Performance Assessment.
- c. In the event that the UHC Companies fail to meet the 2009 tolerance standard for Appeals; Non-clinical of 94%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 6% of the Total Performance Assessment.
- d. In the event that the UHC Companies fail to meet the 2009 tolerance standard for Appeals: Clinical of 97%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 6% of the Total Performance Assessment.
- e. In the event that the UHC Companies fail to meet the 2009 tolerance standard for DOI Complaints of 34%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 3% of the Total Performance Assessment.

3. For the calendar year 2010, the UHC Companies and the Signatory Regulators agree:
- a. In the event that the UHC Companies fail to meet the 2010 tolerance standard for Claim Accuracy of 97%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 12.5% of the Total Performance Assessment.
 - b. In the event that the UHC Companies fail to meet the 2010 tolerance standard for Claim Timeliness of 96%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 12.5% of the Total Performance Assessment.
 - c. In the event that the UHC Companies fail to meet the 2010 tolerance standard for Appeals: Non-clinical of 95%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 10% of the Total Performance Assessment.
 - d. In the event that the UHC Companies fail to meet the 2010 tolerance standard for Appeals: Clinical of 97%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 10% of the Total Performance Assessment.
 - e. In the event that the UHC Companies fail to meet the 2010 tolerance standard for DOI Complaints of 33%, the UHC Companies shall pay the Signatory Regulators the total sum equal to 5% of the Total Performance Assessment.

C. Other Provisions.

1. In determining the UHC Companies' performance with respect to any of the tolerance standards set forth in Paragraph B. above or C. 2. below, 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 Companies' performance with respect to any of the Claim Accuracy, UHC Claim 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.
2. Any assessment due under any provision set forth in Paragraph B., above, shall be paid in the manner and timeframe as set forth in Paragraph C.9. of this Agreement. Any payment due a Signatory Regulator hereunder will be determined by multiplying the applicable payment payable hereunder by the applicable Signatory Regulators' membership percentage, as set forth in Exhibit B., paragraph C, Column (3).
3. For purposes of determining whether there is a deficiency involving Compliance hereunder with respect to any jurisdiction of a Signatory Regulator under paragraph C.10 of this Agreement, the annual tolerance standards shall be as set forth hereinafter:

- a. The tolerance standard for Claim Accuracy shall be 95%;
- b. The tolerance standard for Claim Timeliness shall be 94%;
- c. The tolerance standard for Appeals; Non-clinical shall be 90%;
- d. The tolerance standard for Appeals: Clinical shall be 97%; and
- e. The tolerance standard for DOI Complaints shall be 37%.

In no event will a deficiency be found under paragraph C.10 of this Agreement, unless the data reviewed for the particular benchmark constituted a statistically significant sampling with respect to all periods under review.

EXHIBIT E

Required Reports and Monitoring

1. Reports

The UHC Companies shall provide quarterly (unless subsequently modified) 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 claims processing timeliness as defined in the Benchmarks
- c. National and jurisdiction specific claims 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 claims and dollar impact of claims reprocessed and paid under items a. – i., above (details for each item).

2. Certification

All reports containing national data shall be certified by an officer of the UHC Companies and all reports containing jurisdiction specific data shall be certified by an officer of the UHC Company submitting an Annual Statement to that jurisdiction.

3. Meetings

- a. The UHC Companies shall establish a group of officers with a lead contact and alternate to interact with the Lead Regulators on issues and questions that arise.
- b. The UHC Companies shall meet with the Lead Regulators at least quarterly during the first year and at least semi-annually for two (2) additional years to discuss progress and results.