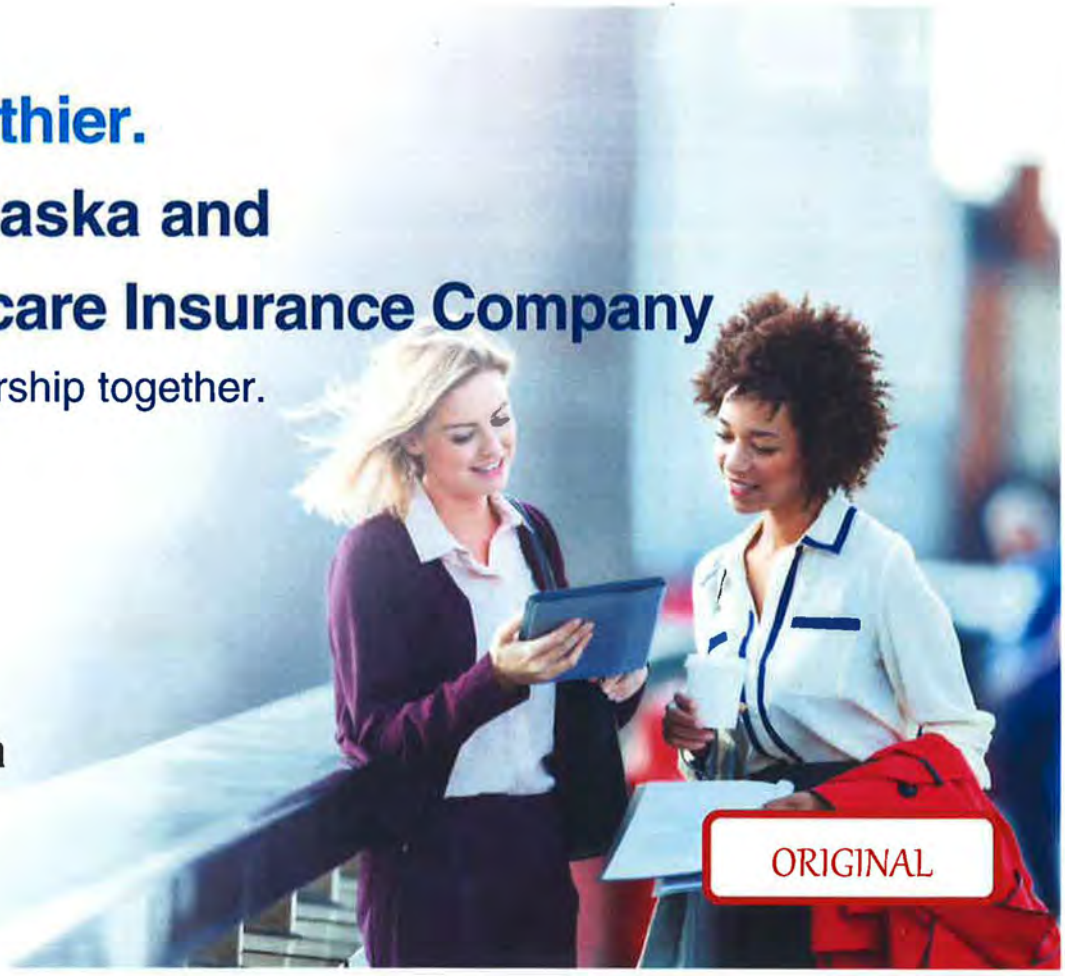
UnitedHealthcare®

Inspiring healthier.

State of Nebraska and UnitedHealthcare Insurance Company

Building health ownership together.



State of Nebraska
RFP#5956 Z1

December 2018

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A Benefits Proposal for

State of Nebraska State Purchasing Bureau

Solicitation Number: RFP 5956 Z1

Due on: December 13, 2018

Issued on: December 11, 2018

UnitedHealthcare®

UnitedHealthcare®

UnitedHealthcare® is the brand name under which a group of affiliated companies collectively market ancillary benefit products, including Critical Illness, Dental, Disability, FMLA Administration, Life, and Vision. To promote ease of understanding for the reader, UnitedHealthcare will be the name used throughout our response except where addressing questions or forms which specifically require the administrating, bidding or underwriting entity to be named. UnitedHealth Group Incorporated ("UHG") is the ultimate parent organization of the legal entities behind the UnitedHealthcare brand, except where noted.

Dental

Our Dental products include self-funded and fully-insured PPO, INO, Indemnity and HMO. Our primary Dental product brand is UnitedHealthcare Dental.

Dental Benefit Providers, Inc. ("DBP") administers fully-insured dental PPO and INO plans nationwide based on availability, as well as self-funded plans (except in CA). In some circumstances the contracting entity for administrative only services may be United HealthCare Services, Inc., a parent company of Dental Benefit Providers, Inc.

Fully-insured PPO and INO plans are underwritten by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of New York based on licensure. In California, our PPO and INO dental plans are administered by Dental Benefit Providers, Inc. d/b/a Dental Benefit Administrative Services.

Dental Benefit Providers of California, Inc. administers self-funded plans in CA, and also offers the UnitedHealthcare Dental, PacifiCare Dental and Pacific Union Dental branded DHMO products. It is a licensed Knox-Keene entity in California regulated by the California Department of Managed Health Care.

Additionally, we offer HMO products which are administered by Dental Benefit Providers, Inc. through the following licensed HMOs:

- Dental Benefit Providers of Illinois, Inc. offers our HMO plan in Maryland and Florida.
- Nevada Pacific Dental offers our HMO plan in the state of Nevada.
- National Pacific Dental, Inc. offers our HMO plan in the state of Texas.
- DBP administers and markets a DHMO plan in Florida through Solstice Benefits, Inc. a licensed Prepaid Limited Health Services Organization Chapter 636 F.S. Solstice Benefits, Inc., is not owned by UHG.

Disability

Our Disability products include Short Term Disability on an administrative services only (ASO) basis, fully-insured Short Term Disability and fully-insured Long Term Disability.

Our Disability products are provided by UnitedHealthcare Insurance Company, Unimerica Insurance Company and in New York by Unimerica Life Insurance Company of New York and in California by Unimerica Life Insurance Company.

Life

Our Life Insurance products are underwritten by UnitedHealthcare Insurance Company, Unimerica Insurance Company and in New York by Unimerica Life Insurance Company of New York and in California by Unimerica Life Insurance Company.

Vision

Our Vision products include self-funded and fully-insured PPO plans. Our Vision product brands are UnitedHealthcare Vision and PacifiCare Vision.

Spectera, Inc. administers the self-funded and fully-insured PPO plans nationwide depending on availability. UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York underwrite fully-insured vision plans depending on licensure. In some circumstances the contracting entity for administrative only services may be United HealthCare Services, Inc., a parent company of Spectera, Inc.

Critical Illness

Our Critical Illness product is underwritten by UnitedHealthcare Insurance Company.

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December 11, 2018

Ms. Teresa Fleming, Buyer
State Purchasing Bureau
1526 K Street
Suite 130
Lincoln, NE 68508

Re: The State of Nebraska RFP 5956 Z1

Dear Ms. Fleming,

On behalf of UnitedHealthcare, I am pleased to submit our response to The State of Nebraska's RFP for disability benefits. Today's successful organizations understand that a high quality, cost-effective benefit package can be a key factor in attracting and retaining the best talent available. We are committed to providing the benefits package with the highest possible value to The State of Nebraska and its employees.

Our disability portfolio includes a wide range of short- and long-term disability benefit options, enhanced by flexible plan designs and value-added services. We also offer an advantage our competitors cannot match: the security and vast financial and technological resources of our ultimate parent organization, UnitedHealth Group Incorporated, a Fortune 25 company and established industry-leader ranked the most admired healthcare company in 2011 and 2012 by *Fortune* magazine.

A disability lasting three months or longer will strike roughly three in 10 workers. Many American families couldn't go one month, let alone two or three years, without the support of a regular income. We offer short- and long-term disability options that can provide a steady flow of income to help maintain a consistent standard of living in the case of a disability.

Employees can find life's challenges stressful and overwhelming. Untreated personal problems can affect the workplace in costly ways, including poor performance, increased turnover, absenteeism, accidents and greater use of medical benefits. To reduce these problems and provide employees with the support they need, we offer a member assistance program as part of our long-term disability product at no additional premium cost.

Our innovative Bridge2Health wellness program is designed to positively impact overall employee health – and the health of your organization– by empowering members with information, resources and support so they can make better decisions that may lead to better outcomes. The key differentiators of our program are early intervention and our ability to provide medical, disability and behavioral health case management coordinated by a single case manager under one roof.

Thank you for your consideration of our proposal. I welcome the opportunity to discuss it with you and answer any questions you may have.

Sincerely,

Jane L Perez, CEBS
Strategic Client Executive
UnitedHealthcare National Accounts
P O Box 9472, NE910-1000
Minneapolis, MN 55440-9472
Office: 763- 283-3597
Cell: 402-312-3282
Email: jane_l_perez@uhc.com

UnitedHealthcare®

Section 2

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free workplace.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

__X__ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	UnitedHealthcare Insurance Company
COMPLETE ADDRESS:	185 Asylum Street Hartford, CT 06103
TELEPHONE NUMBER:	(860) 702-5000
FAX NUMBER:	(860) 702-7916
DATE:	December 11, 2018
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	James Bedard, Authorized Representative

Section 3

A

Attachment A

Contractor Requirements Matrix

Request for Proposal Number 5956 Z1

Bidder Name: UnitedHealthcare Insurance Company

Bidders should provide a response to each of the following Contractor requirements below.

	CONTRACT ADMINISTRATION
1.	Be licensed to conduct business in the State of Nebraska and be responsible for administering the State's STD plan and LTD plan in accordance with all applicable laws, regulations, IRS requirements, and State of Nebraska requirements.
	Response: **Confirmed. We are licensed to provide disability insurance in all 50 states plus the U.S. Virgin Islands.** **We confirm that our organization is currently operating in material compliance with all relevant federal and state laws and regulations relating to the services we are proposing.**
2.	A commitment to work cooperatively with the State of Nebraska and provide with at least one day-to-day contact person for account management of the STD and LTD contract.
	Response: **Confirmed. The contract manager will be Jane Perez, Strategic Client Executive. She will serve as your main point of contact.**
3.	There will be no restrictions or benefit limitations for pre-existing conditions applied to any employee under the plan.
	Response: **Confirmed.**
4.	Accept the current enrollment files for the State's employees.
	Response: **Confirmed.**
5.	Review all plans, draft plan abstracts, and confirm plan provisions with the State.
	Response: **Confirmed.**
6.	Draft, revise, and finalize the policy and benefit summaries (Summary Plan Descriptions (SPD)/booklets) for review by the State before February 12 of each calendar year.
	Response: **We will provide a policy and certificate of coverage, and include all necessary rounds of review by the State of Nebraska (the State).** **We will provide a certificate of coverage and policy to the State within 45 business days of receipt of all necessary policyholder information.** **SPDs that summarize the benefits provided under the plan are specific to self-funded plan members. We provide a certificate of coverage for fully insured plan members.**
	Provide SPDs in an electronic format for access via internet or intranet.

7.	Response: **We will send Certificates of Coverage to the State electronically, which can be posted to your intranet site.** **SPDs that summarize the benefits provided under the plan are specific to self-funded plan members. We provide a certificate of coverage for fully insured plan members.**
8.	Deliver an Administration Manual containing all user guidelines on such matters as eligibility, reports, plan summaries and procedures 60 days prior to plan year.
	Response: **Confirmed.**
9.	State staff portal for eligibility updates, eligibility validation, uploading documentation, pulling management reports, etc.
	Response: **Confirmed. Our customer portal, eAdministration, offers a suite of resources to help you with short- and long-term disability.** **Our portal provides you with easy access to:** ■ **e-Bill services: Enables you to update billing information, access a 12-month history of invoices/ payments and make electronic payments** ■ **Forms library: Provides access to claim, beneficiary, enrollment and medical underwriting forms** ■ **Report portal: Contains various claim and underwriting reports (reports may not be available for all group sizes)** **Please note that as you will have self-administered billing, we do not maintain eligibility or enrollment data; therefore, you do not need to provide files or forms.**
10.	Employee/claimant portal for monitoring claim status, communications, uploading documentation, etc.
	Response: **Members can find financial protection claim forms and customer service contact information on our member website, myuhc.com, which enables them to download and print forms without needing to contact the call center. However, members cannot upload documentation to the employee portal at this time.**
11.	Communications (phone calls, emails) should be responded to within 24 hours. The customer service department shall provide telephone support to members via a toll free number and maintain telephone technology for the hearing and visually impaired. Describe your customer service process, including the hours of operation and methods of contact.

	Response: **Confirmed. Calls received after 5 p.m., CT, route directly to an after-hours voicemail box. We check voicemail messages at 8 a.m. and return the call by 10 a.m. the following day.** **We do not currently offer the capability for members to contact customer service via email.** **We provide nationwide customer service through our single toll-free call center. We offer a toll-free TDD service for the deaf and hearing-impaired populations. We are committed to ensuring that each member has access to customer service and quality care.** **All claim calls are received in our customer contact center where they are answered on a first-in first-out basis by our customer service representatives. All inbound calls to intake and member services are recorded. In the event the customer service representative cannot assist the caller, the call is transferred to the claim specialist. Calls with claim specialists are not recorded. They are, however, documented in the member's claim file. At this time, we keep all recorded call data indefinitely for historical reporting. Call center metrics are measured and reported on internally, as well, however, this information is not shared with the policyholder.** **Our call center operates Monday through Friday from 7 a.m. to 5 p.m., CT. The call center is staffed with experienced call center representatives who can answer general benefits questions as well as address specific company-sponsored benefit plan information. Claim specialists are available Monday through Friday from 7 a.m. to 4 p.m., CT.**
12.	Initial claim intake, validation of initial and continuing disability.
	Response: **Confirmed. Our disability claim processing unit handles all short-term disability and long-term disability claims. A single platform combines all claim administration elements, including benefit design, claim payment and claim history.** **Upon receipt of a claim, a disability claim specialist is assigned. This person is in constant contact with the member throughout the course of his or her disability. The relationship begins within five business days when the DCS sets up a telephone interview with the member.** **Concurrent with claim assignment, our disability claims are clinically pre-screened at the onset (with the exception of normal pregnancy and delivery). Our nurses review claims for proper diagnosis and treatment plans, comorbidities, restrictions and limitations. They also take note of a member's current functional capacity and request any additional medical information that is needed. The disability claim specialist evaluates claims to determine if consultation with our on-site clinical resources is appropriate. If an adverse claim determination is considered, and the adverse determination is based in part on medical information presented in support of the claim, a medical review must be completed prior to the final determination.** **Once a claim is approved, based on the action plan, the disability claim specialist regularly verifies the member is still disabled and continually evaluates the member's opportunities for the following scenarios:** ■ **Return to work** ■ **Receive Social Security disability benefits** ■ **Transition into another career**

13.	Provide routine underwriting and actuarial services.
	Response: **We will provide a wide range of underwriting services, including overall program accounting, claim projections, calculation of premium equivalent rates, projections of the cost impact of benefit design changes, reserve estimates and more.** **We do not provide certified actuarial services.**
14.	Make determinations with respect to submitted claims, including claim investigation and analysis prior to payment.
	Response: **Confirmed. Our disability claim models have been in place since 2007, with periodic updates implemented as needed in order to remain compliant with state and federal legislative changes. Our comprehensive set of claims management guidelines and resources allow us to adjudicate each claim in an objective manner based on its unique properties and applicable policy.** **Within 48 hours of receipt, we assign a complete disability claim to the disability claim specialist. Within five business days from receipt of the claim, the disability claim specialist:** ▪ **Completes the initial review** ▪ **Conducts a telephone interview with the member** **We thoroughly investigate claims and establish return-to-work expectations upfront based on the member's restrictions, limitations, abilities, treatment plan, prognosis and reasonable recovery time. The disability claim specialist makes every attempt to render a claims decision within 45 days of receipt of a complete claim and maintains constant contact with the member through the claim's life, so there are no surprises for you or the member.**
15.	Maintain claim files to support payment, denials and appeals. Documentation must be legally acceptable and readily accessible.
	Response: **We confirm we will maintain claim files to support payment, denials and appeals. Our claim systems provide detailed notes on the current status of claims. However, in an effort to safeguard against any potential violation of corporate, state or federal regulations regarding the protection of private information, customers are not provided with direct access to our claim systems.** **In the alternative, we offer a variety of reporting options that provide necessary information to our customers. Our standard disability reports contain information on claims by diagnosis, benefits paid, claims by division, diagnostic category and claim totals. Paid Claim reports and Open and Closed Claim reports are also available. The following reports are also available on an ad hoc basis: Claim Incident, Claim Status, Data Analyzer, Disability Benchmarking, Disability Top Ranking Diagnostic, Key Indicators, List Time Trends, New Claims Submitted Trends, and Payments and Deductions.**
16.	Medical review and integration with medical administrator for co-management of claim.
	Response: **Confirmed. As your medical carrier, medical review and integration for co-management of claims will be seamless. We handle claim payment and case management on the same system, and the components are fully integrated. Our disability claim processors combine each element, including benefit design, claim payment and claim history to create a cohesive case file. Multiple resources have access to the file at the same time and can conduct simultaneous reviews. The result is an enhanced claim management experience for our customers.**

17.	Evaluate and recommend Return to Work options and accommodations.
	Response: **Confirmed. Once an employee returns to work in a residual capacity, the claims specialist maintains open communication with the employee, and the employer when necessary, to ensure the employee is aware of the status of his/her disability benefits. To ensure accurate benefit payment, the employee will be required to submit earnings documentation for review and calculation by our certified public accountant (CPA) prior to the release of benefits. Written communications to the employee will reference the relevant policy wording, including explanation of the return to work provision and the earnings loss percentage required to continue to be eligible for benefits.** **If an employee is released to full or part-time duty with restrictions, and the State is not able to accommodate the restrictions without modifying the job duties or the worksite, the claim specialist will engage our clinical and vocational resources to discuss potential return to work opportunities. Accommodations can range from modifying or eliminating a job duty, to adjusting a work schedule or to purchasing specialized ergonomic equipment.** ■ **If modifications in the claimant's duties are required to support part-time return to work, these modifications will continue for as long as they are medically supported or for as long as the employer can support them.** ■ **If either a physical modification to the worksite or adaptive equipment is needed, the Worksite Modification Benefit may be accessed to assist with the associated expense. This benefit is available to a covered person on a one-time only basis for up to the maximum benefit amount (generally $5,000).**
18.	Transition from STD to LTD, when applicable.
	Response: **Confirmed. The transition from short-term to long-term disability can be both physically and emotionally difficult for members. We offer a seamless transition to help ease that burden. As a member approaches the end of the short-term disability benefit, the short-term disability claim specialist notifies the long-term disability claim specialist of the upcoming transition. The long-term disability specialist will then conduct a thorough review of the case and request the information necessary to render a decision before the member's short-term disability ends.** **The long-term disability specialist works closely with you, the member and attending physician to ensure everything is received within 45 days of receiving a complete claim. We also inform the member of the change in payment: from weekly short-term disability payments to monthly long-term disability payments. Our due diligence means no surprises for you or the member.** **Because our claim process is fully integrated, there is consistency in how we manage claims and share data. The member's information is readily available to all claim specialists, which prevents us from having to request the same information twice. The long-term disability claim specialist is in constant contact with the member throughout the transition and beyond.**
19.	Fraud monitoring and detection.

	Response: **Confirmed. We built fraud identification processes directly into our claims management practices. We use external vendors to complete background investigations, member visits and surveillance to aid in fraud detection.** **During the initial review and ongoing management of a disability claim, we may use surveillance to obtain additional information (e.g., work activity) or confirm a member's functional capacity. The need for surveillance is determined on a case-by-case basis, with the primary reason to clarify suspicious claim inconsistencies.** **In the event we suspect fraudulent activity has occurred, we refer the claim to our special investigations unit vendor. The vendor will complete an independent investigation and advise us on the appropriate next steps.** **We also provide annual fraud training to our claim staff and report all potential fraud to the proper state authorities. We have found these fraud prevention measures substantially limit the ability for a member to successfully submit a fraudulent claim.**
20.	Provide ongoing assistance in administration, claim adjudication, and general problem solving. Periodic account servicing meetings will be held with the account manager and claims support group.
	Response: **Confirmed. Your Strategic Client Executive, Jane Perez, and Jelena Edwards, Client Manager will provide support in administration, claims adjudication and general problem solving. They will also schedule regular meetings to discuss your utilization and claims experience. Quarterly meetings may include claim cost information and topics such as open-enrollment planning, addition of new services and benefit changes.**
21.	Refrain from issuing any external communications material that mentions the State's benefit plans without written approval from the State. This includes newsletters and publications to agents, brokers and consultants.
	Response: **Confirmed.**
22.	Design, submit for approval, and print enrollment forms with the State's logo for use by plan participants to enroll, and change their coverages, in accordance with plan provisions.
	Response: **Because you will have self-administered billing, we do not maintain eligibility or enrollment data; therefore, you do not need to provide files or forms. As such, this question is not applicable.**
23.	When customized printing is requested by the State, present a complete draft and subsequent proof to the State for sign-off. The Contractor must ensure that logo placement and color requirements are met. Contractor will be responsible for costs of printing booklets, certificates, or SPDs as required.
	Response: **As previously mentioned, we are happy to provide samples of communications to the State for review and approval prior to distribution.** **We will send certificates of coverage to the State electronically, which can be posted to your intranet site.**
24.	Handles problems and complaints initially and pursues all other inquiries in a timely fashion and advises State of NE of escalated issues and recurring patterns.

	Response: **We measure and track life and disability complaints and any procedures created as a result. However, this information is not shared with the policyholder.** **The client manager and strategic client executive share authority for issue resolution and escalation.** **Based on the type and severity of the escalation, the client manager reaches out to internal leadership resources within UnitedHealthcare to assist in resolution. During this process, the client manager involves the strategic client executive through regular conversations or review of Issue/Opportunity logs.** **We operate on a single platform that tracks turnaround time performance by customer across all departments. We review issue resolution data on a weekly basis with account management teams to ensure service level agreements are met.**
25.	Develops enrollment materials. Provide an example of an employee enrollment kit.
	Response: **Because you will have self-administered billing, we do not maintain eligibility or enrollment data; therefore, you do not need to provide files or forms. As such, this question is not applicable.**
	IMPLEMENTATION
26.	Provide a detailed timeline and implementation plan including deadlines set forth in this RFP including State resources and personnel required.
	Response: **Please refer to our Sample Implementation Timeline, included in Section 12, which includes deadlines and responsibilities.** **In order for us to successfully implement business, we need a completed application and a binder check. After that, we perform the majority of the tasks associated with implementation. It is our overarching goal to assume as much of the responsibility as possible, while keeping you informed of details, progress and any deliverables we may need from you.**
27.	No statement of health or medical evidence will be imposed upon the initial group of covered employees.
	Response: **We ask for evidence of insurability when an employee enrolls more than 31 days after first becoming eligible.**
28.	Provide coverage to all present participants enrolled on the program effective date. No active employees or disabled employees shall lose coverage as a result of a change in the Contractor.
	Response: **Confirmed.**

29.	Any "actively at work" requirements will be waived for current covered employees.
	Response: **Confirmed with underwriting approval.**
30.	Identify any programs, systems, or administrative opportunities that your organization can provide during the implementation process that would be beneficial to the State.
	Response: **We strive to offer new and unique ways for you to do business with us. Here are just some of the things we offer to improve your experience:** ■ **Improving the episode of care: We leverage the vast clinical resources and expertise of companies throughout the UnitedHealth Group enterprise to improve and enhance the health and well-being of our members. Bridge2Health is our proactive approach to wellness that uses health plan and specialty plan data to identify members with complex conditions. This value-added service provides these at-risk individuals with resources to help them take control of their health. Through better integration, we can help influence healthier outcomes, improved productivity, reduced absenteeism and lower costs.** ■ **Member Assistance Program: Our long-term disability member assistance program offers confidential assistance to employees and their families for consultation, financial, services and referrals to legal and community resources. We also offer online access to an interactive website that provides tools to help enhance your work, health and life at liveandworkwell.com.** ■ **Special features: We offer optional benefit riders, such as portability, catastrophic loss and cost-of-living adjustment (COLA). In addition, we provide leave management services for tracking and reporting employee absences due to short-term disability, family and medical leave and other absences.** ■ **Ease of use and administration: Our internal experts in sales, service, underwriting and claims management function as a single, multi-faceted team who work in tandem to ensure your account is running smoothly. We take a whole case underwriting approach to offer consolidated quotes and benefits packages that are geared toward the State's needs.** ■ **Claims management: Our disability claims management staff has 15 years of experience, on average, of working with claimants and their timely and appropriate return to work.** ■ **Improved flow of information: We provide simple and real-time access to important information through our self-service online tools and automated call center.** ■ **Financial strength: We currently have a rating of AA by Standard and Poor's (United HealthCare Insurance Company).**
	REPORTING
31.	Monthly, quarterly, semi-annual, and annual reporting including but not limited to: Utilization, approvals/denials of coverage, etc.

	Response: **Confirmed. You may access disability insurance reports at any time. Our reports are available online and the data is updated nightly, so you choose the frequency that works best for you.** **In our standard disability claim reports, we include:** ■ **Benefits paid** ■ **Claims by division** ■ **Claim totals** **We provide ad hoc reports upon request.**
32.	A year-end financial accounting for the program within 60 days of the contract anniversary date.
	Response: **Confirmed.**
33.	Maintain an internal audit program and provide the State with a copy of the most recent internal audit report upon request.
	Response: **We maintain an internal audit program. We use the following quality review measures to monitor the timeliness and accuracy of our claim adjudication processes:** ■ **Statistical Review – Assess financial and procedural accuracy of claim processing and satisfy internal and external reporting needs** ■ **Processor Review – Conduct baseline audits to measure the quality of individual processors** ■ **New Hire Trainee Certification Review –Quickly identify training gaps and training opportunities** ■ **End-to-End Audit – Address current quality assessment gaps; validate that all supporting systems and data are loaded correctly; verify the accuracy of supporting data** **We offer you and your employees the highest quality in claims processing through these processes.** **Currently, we will work with the State to provide any necessary internal audit information.**
PERFORMANCE GUARANTEES	
34.	Do you have a formal performance guarantee program? If so, please provide a copy.
	Response: **We have provided Disability Performance Guarantees. Please refer to Section 4.**
BILLING	
35.	Attach a description of premium billing procedures.

	Response: **We will continue to provide the State with self-billing capabilities.** **SELF-BILL CAPABILITIES** **We offer self-bill capabilities to all of our customers. We have convenient online billing statements, an easy-to-use self-bill template in Excel and several premium payment options.**
36.	Maintains a process for the correction of under and over payments.
	Response: **If we determine a member is reasonably entitled to another income benefit that is offset from the disability benefit, we contact the member via phone and in writing. We explain the effects of the other income benefit to the member and ask him/her to select a payment preference on the payment options form for either of the following:** ■ **He or she can receive a reduced benefit in advance of the subsequent other income benefit award (e.g., the Social Security application is pending but has not yet been approved) in order to avoid an overpayment on the claim.** **or** ■ **He or she can receive an unreduced benefit until the other income benefit award has been finalized, as long as the member agrees to repay any resulting overpayment immediately.** **The payment options form must be signed and returned to the disability claim specialist administering the claim.**
37.	Withhold Medicare taxes from the disabled employee's disability benefits and remits them to the federal government.
	Response: **For fully insured disability customers, we are responsible for withholding and depositing (under our employer identification number) the employees' tax withholding, which includes the employees' portion of FICA and any voluntary state and federal income taxes.** **We generally transfer employer tax liability back to the employer, which includes the deposit of the employer share of FICA, SUTA, FUTA and W-2 reporting, unless the employer contracts with us for W-2 reporting or W-2 and FICA match reporting. Unemployment tax responsibility remains with the employer.**
38.	Remits the State's portion of Medicare tax (from a State Medicare matching Fund) to the federal government.
	Response: **Regarding remitting the State's portion of the Medicare tax to the federal government, we generally transfer employer tax liability back to the employer, which includes the deposit of the employer share of FICA, SUTA, FUTA and W-2 reporting, unless the employer contracts with us for W-2 reporting or W-2 and FICA match reporting. Unemployment tax responsibility remains with the employer.**

Section 4

A

A Benefits Proposal for

State of Nebraska

RFP #5956 Z1

Issued on: December 5, 2018

UnitedHealthcare®

Why Choose UnitedHealthcare?

Cost Savings

Get administrative credits when purchasing more than one plan from UnitedHealthcare. The more you bundle, the more you save.

Convenience

The advantages available when purchasing multiple products include:

- One account management team
- Simplified eligibility and enrollment process
- Consolidated billing
- One dedicated customer service line and member website

Better Health

To help your employees make better health care decisions, all members receive actionable health and wellness education. When you purchase medical and specialty products together, we leverage employee claims data to provide personalized recommendations. We call that approach Bridge2Health.

- For individuals with specific chronic illnesses, our targeted outreach encourages them to receive care that can improve their health and reduce costs.
- For members who file disability claims, case managers help manage their recovery so they can return to health and return to work.

Bridge2Health is available to groups with medical coverage and one or more specialty products. Ask your consultant or UnitedHealthcare representative for participation requirements.

Where else can you find as much value from one organization? Now is the time to discover the strength of our UnitedHealthcare Specialty Benefits product portfolio.

About UnitedHealth Group®

UnitedHealth Group is a diversified health and well-being company dedicated to helping the health care system work better. UnitedHealth Group's mission is to help people live healthier lives by:

- Seeking to enhance the performance of the health system and improve the overall health and well-being of the people the company serves and their communities;
- Working with health care professionals and other key partners to expand access to quality health care so people get the care they need at an affordable price; and
- Supporting the physician/patient relationship and empowering people with the information, guidance and tools they need to make personal health choices and decisions.

Short Term Disability Insurance	Class 1 Core Primary
Legal Entity	**United Healthcare Insurance Company**
Eligibility	All Active Full Time and Regular Part time Employees working a minimum of 20 Hours per week.
Basic Annual Earnings Definition	The average weekly earnings received from the Covered Person's Employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings do not include commissions, bonuses, overtime pay, and other extra compensation.
Benefit Qualification	
Definition of Disability	Residual
Elimination Period-Accident	0 days
Elimination Period-Sickness	7 days
First Day Hospital	Excluded
Recurrent Disability	14 days
Coverage Type	Non-Occupational
Maternity	Treated like any other illness
Volume Basis	Total Covered Benefit
Benefits Payable	
Benefit Type	Benefit Percent
Benefit Percentage	60.0%
Maximum Weekly Benefit	$1,731
Minimum Weekly Benefit	$25
Social Security Integration	Family
Maximum Benefit Duration	26 weeks
Limitations and Exclusions	
Pre-existing Conditions Exclusion	3/12
Exclusions	Standard
Additional Benefits	
Lump Sum Survivor Benefit	Lesser of $3,000 or 3 weeks Gross
Rehabilitation Services	Included
Telephonic Claim Intake	Included
Employer FICA Match	Not Included
Assumed Enrollment and Rates	
Number of Employees	TBD
Volume of Insurance	TBD
Rate Basis	Age-banded per $10 of Total Covered Weekly Benefit
Monthly Rate	Under 25 $0.910 25 - 29 $0.897 30 - 34 $0.910 35 - 39 $0.757 40 - 44 $0.812 45 - 49 $0.801 50 - 54 $0.914 55 - 59 $1.119 60 - 64 $1.410 65+ $1.621
Monthly Premium	TBD
Annual Premium	**TBD**
Employer Contribution	0%
Current Participation	TBD
Minimum Participation	25%
Broker Commissions	0%
Rate Guarantee (in months)	36 Months

General Assumptions

- We reserve the right to change rates and/or plan provisions if the number of lives or volume of insurance change by more than 10% before, on, or after the effective date listed above or if factors used to generate this quote such as group demographics or effective date are changed, found to be incomplete or incorrect.

- Rates assume no changes in legislation or regulation that affects the benefits payable, eligibility or contract.

- Rates assume standard administrative services including Claims & Data processing, Enrollment & Billing, Customer Service, Case Management, Provider Relations, and Reporting

- Assumed contract situs is Nebraska

- Employees must be U.S. citizens or residents regularly working and living in the U.S. Coverage for U.S. citizens working outside of the U.S. must be approved in writing by us. Approval depends on locale and length of assignment.

- Employers assumed primary business is classified as 9111 SIC Code.

- Rates may increase on renewal in accordance with the terms of the policy.

STD Assumptions

A new pre-existing condition limitation period will apply on the date of any increase in coverage.

In the event of a disability, the claimant must remain a permanent resident of the United States and must be continuously under the care of a Physician as defined in our policy.

Our quote assumes the employer participates in Social Security and provides Workers Compensation for all eligible employees.

Benefit may be subject to Other Income Benefit Offsets outlined in policy.

Continuity of Coverage/No Loss No Gain for previously covered employees is included.

Our contract is for non-occupational coverage only and does not replace statutory mandated coverage.

The Policy will not cover a disability if it is due to: intentionally self-inflicted injures, commission or attempted commission of a felony, participation in a riot, war, act of war of armed conflict between organized military forces or while the covered person is incarcerated or under house arrest.

This proposal is valid for 90 days from the issued date, unless otherwise noted within this document.

Brokers and agents may receive commissions, bonuses and other compensation for selling the products presented in this proposal. The cost of this compensation may be directly or indirectly reflected in the premium or fees for those products. Contact your broker and/or agent if you have questions regarding their compensation relating to products in this proposal.

This proposal is subject to negotiation and execution of a written agreement, which will supersede the proposal contents. This proposal does not constitute an agreement, and is based on assumptions made from the written information in our possession and provided by you. We retain the right to modify our proposal if the information upon which this proposal is based is changed or is supplemented.

We consider much of the information contained in the proposal to be proprietary or otherwise confidential, and are releasing this proposal to you on the understanding that you and your representatives will only use it, and any data included in the proposal, for the specific purpose of evaluating its content. If this is not consistent with your understanding, please notify us before reviewing the proposal.

In addition, by accepting and reviewing the contents of this proposal, you and your agents or other designees agree, to the extent permitted by law, that certain information contained herein, or other information provided to you in connection with this proposal response or associated request for proposal (RFP), is proprietary and/or confidential to UnitedHealthcare and its related entities, and may not be copied, used, distributed or disclosed without prior written consent from an authorized representative of UnitedHealthcare and its related entities, other than is necessary to evaluate this proposal.

A Benefits Proposal for

State of Nebraska

RFP #5956 Z1

Issued on: December 05, 2018

Why Choose UnitedHealthcare?

Cost Savings

Get administrative credits when purchasing more than one plan from UnitedHealthcare. The more you bundle, the more you save.

Convenience

The advantages available when purchasing multiple products include:

- One account management team
- Simplified eligibility and enrollment process
- Consolidated billling
- One dedicated customer service line and member website

Better Health

To help your employees make better health care decisions, all members receive actionable health and wellness education. When you purchase medical and specialty products together, we leverage employee claims data to provide personalized recommendations. We call that approach Bridge2Health.

- For individuals with specifc chronic illnesses, our targeted outreach encourages them to receive care that can improve their health and reduce costs.
- For members who file disability claims, case managers help manage their recovery so they can return to health and work.

Bridge2Health is available to groups with medical coverage and one or more specialty products. Ask your consultant or UnitedHealthcare representative for participation requirements.

Where else can you find as much value from one organization? Now is the time to discover the strength of our UnitedHealthcare Specialty Benefits product portfolio.

About UnitedHealth Group®

UnitedHealth Group is a diversified health and well-being company dedicated to helping the health care system work better. UnitedHealth Group's mission is to help people live healthier lives by:

- Seeking to enhance the performance of the health system and improve the overall health and well-being of the people the company serves and their communities;
- Working with health care professionals and other key partners to expand access to quality health care so people get the care they need at an affordable price; and
- Supporting the physician/patient relationship and empowering people with the information, guidance and tools they need to make personal health choices and decisions.

Long Term Disability	Class 1 Voluntary Core Primary	
Legal Entity	**United Healthcare Insurance Company**	
Eligibility	All Active Full Time and Regular Part Time Employees working a minimum of 20 hours per week	
Basic Annual Earnings Definition	The average monthly earnings received from the Covered Person's Employer for the 12-month period ending just prior to the date of Disability. Pre-Disability Monthly Earnings includes commissions, averaged over the lesser of the most recent 24-month period or the Covered Person's period of employment. It does not include bonuses, overtime pay, and other extra compensation.	
Benefit Qualification		
Definition Of Disability	Residual	
Own Occupation Period	24 months (2 year) own occupation	
Earnings Test	80% Own Occupation / 80% Any Occupation	
Requires Loss of Earnings/Duties	Loss of Earnings and Duties	
Elimination Period	180 days	
Accumulation of Elimination Period	30 Days	
Recurrent Disability	6 Months	
Benefits Payable		
Benefit Percentage	60%	
Maximum Monthly Benefit	$7,500.00	
Minimum Monthly Benefit	$100	
Guaranteed Issue Benefit	$7,500.00	
Social Security Integration	Full Family	
Maximum Benefit Duration	Reducing Benefit Duration w/SSNRA	
Limitations and Exclusions		
Pre-exisiting Conditions Exclusion	3/12	
Mental and Nervous Limitation	24 months (per disability)	
Substance Abuse Limitation	24 months (per disability)	
Subjective Symptoms Limitation	No Limit	
Additional Features		
Work Incentive Benefit	12 months	
Survivor Income Benefit	3 months Gross	
Rehabilitation	Voluntary	
Accelerated Benefit	Included	
Employer FICA Match	Included without Reimbursement	
Child Care Benefit Amount	$350.00	
Child Care Benefit Duration	12 months	
eAPP Evidence of Insurability	Included	
Family Income Benefit	1 year	
Member Assistance Program	Included	
Portability	Included	
Transplant Benefit	Elimination Period waived for Disability resulting from organ donation. Limited pay period to 12 months.	
Vocational Rehab Benefit	10% to $1000	
Assumed Enrollment and Rates		
Number of Eligible Employees	15,465	
Monthly Covered Payroll (MCP)	TBD	
Rate Basis	Age-Banded per $100 of Monthly Covered Payroll	
Monthly Rate	Under 25	$0.05
	25-29	$0.08
	30-34	$0.12
	35-39	$0.14
	40-44	$0.17
	45-49	$0.24
	50-54	$0.36
	55-59	$0.43
	60-64	$0.45
	65-69	$0.47
	70+	$0.50
Monthly Premium	TBD	
Annual Premium	**TBD**	
Employer Contribution	0%	
Current Participation	NA	
Minimum Participation Requirements	25%	
Employee Contribution Tax Basis	Post-Tax	
Limitation and Exclusions	Standard	
Broker Commissions	Flat - 0%	
Rate Guarantee (in Months)	36 Months	

General Assumptions

- UnitedHealthcare reserves the right to change rates and/or plan provisions if the number of lives or volume of insurance change by more than 10% before, on, or after the effective date listed above or if factors used to generate this quote such as group demographics or effective date are changed, found to be incomplete or incorrect.

- Rates assume no changes in legislation or regulation that affects the benefits payable, eligibility or contract.

- Rates assume standard administrative services including Claims & Data processing, Enrollment & Billing, Customer Service, Case Management, Provider Relations, and Reporting

- Assumed contract situs is Nebraska

- Employees must be U.S. citizens or residents regularly working and living in the U.S. Coverage for U.S. citizens working outside of the U.S. must be approved in writing by us. Approval depends on locale and length of assignment.

- Employers assumed primary business is classified as 9111 SIC Code.

- Rates may increase on renewal in accordance with the terms of the policy.

LTD Assumptions

Premium is calculated using Total Monthly covered Payroll.

A new pre-existing condition limitation period will apply on the date of any increase in coverage.

In the event of a disability, the claimant must remain a permanent resident of the United States and must be continuously under the care of a Physician as defined in our policy.

Our quote assumes the employer participates in Social Security and provides Workers Compensation for all eligible employees.

Benefit may be subject to Other Income Benefit Offsets outlined in policy.

Continuity of Coverage/No Loss No Gain for previously covered employees is included.

The Policy will not cover a disability if it is due to: intentionally self-inflicted injures, commission or attempted commission of a felony, participation in a riot, war, act of war of armed conflict between organized military forces or while the covered person is incarcerated or under house arrest.

This proposal is valid for 90 days from the issued date, unless otherwise noted within this document.

Brokers and agents may receive commissions, bonuses and other compensation for selling the products presented in this proposal. The cost of this compensation may be directly or indirectly reflected in the premium or fees for those products. Contact your broker and/or agent if you have questions regarding their compensation relating to products in this proposal.

This proposal is subject to negotiation and execution of a written agreement, which will supersede the proposal contents. This proposal does not constitute an agreement, and is based on assumptions made from the written information in our possession and provided by you. We retain the right to modify our proposal if the information upon which this proposal is based is changed or is supplemented.

We consider much of the information contained in the proposal to be proprietary or otherwise confidential, and are releasing this proposal to you on the understanding that you and your representatives will only use it, and any data included in the proposal, for the specific purpose of evaluating its content. If this is not consistent with your understanding, please notify us before reviewing the proposal.

In addition, by accepting and reviewing the contents of this proposal, you and your agents or other designees agree, to the extent permitted by law, that certain information contained herein, or other information provided to you in connection with this proposal response or associated request for proposal (RFP), is proprietary and/or confidential to UnitedHealthcare and its related entities, and may not be copied, used, distributed or disclosed without prior written consent from an authorized representative of UnitedHealthcare, other than is necessary to evaluate this proposal.

Disability Performance Guarantees

Service	Metric	Measurement	How Measured	Fee at Risk
Client Implementation	Enrollment materials	Enrollment materials completed/shipped within mutually agreed upon timeframe	Implementation Tracking	**.3% of premium**
	Draft certificate issued	20 days from receipt of set up information	Implementation Tracking	**.3% of premium**
	System Readiness	Systems ready for claims/customer service within the following days from receipt of complete set up information: • 26 days list billed groups • 21 days for self billed groups	Implementation Tracking	**.15% of premium**
Claim Processing*	STD and LTD Claims – New Claim Action	98% of claims will be acknowledged, additional information requested, or pended, paid or denied, within five business days of receipt of claim notification.	Quarterly Intake Report	**.3% of premium**
	Complete STD Claim – Decision	98% of claims be approved and payment issued, or claims denied and letter mailed in three business days following receipt of all information necessary to make a claim decision.	Quarterly Claim Decision Report	**.3% of premium**
	Complete LTD Claim – Decision	98% of claims approved and payment issued, or claims denied and letter mailed in five business days following receipt of all information necessary to make a claim decision.	Quarterly Claim Decision Report	**.3% of premium**
	Financial Accuracy – STD and LTD	98% of claims will have all appropriate taxes, deductions and offsets in place, the claim is calculated and entered into the system correctly.	Quarterly Financial Report	**.3% of premium**
Employer Reporting*	Accurate reporting provided 45 days after the end of the quarter	Reporting sent out to employer	Reporting send date	**.3% of premium**
Customer Service*	Average speed of answer	80% in less than 30 seconds	Call Center Statistics	**.3% of premium**
	Abandonment Rate	<5% abandonment rate	Call Center Statistics	**.3% of premium**
Account Management	Client Satisfaction	UHCSB performs satisfactory ongoing, day-to-day account management in the opinion of the client's HR and/or benefits staff.	Based on average score of 3 out of 5 on standard client survey. UHCSB will have one quarter to remedy any issues and surveys will be rescored prior to annual assessment.	**.15% of premium**
			Total at Risk	**The lesser of 3% or $50,000**

*Book of Business level reporting
Reporting will be provided quarterly with annual payout of any fees at risk.

Section 5

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VI as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We make every effort to ensure that our proposal reflects the same benefits described in our contract. Our proposal provides a summary of benefits and definitions; whereas our contract provides in-depth details and is the document that will rule in a discrepancy.** **Regarding sample certificates of coverages, please refer to our Sample Short-Term Disability certificate of coverage and Policy and Sample Long-Term Disability Certificate of Coverage and Policy, included in Section 12.** **Included below are deviations to specific requirements within II. Terms and Conditions of the State of Nebraska's (the State's) RFP.**

The contract resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Contractor's proposal (RFP and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable ; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**The contract manager will be Jane Perez, Strategic Client Executive. She will serve as your main point of contact.**

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

Confirmed.

C. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

Noted.

D. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

E. CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Not applicable. Changes are issued in the form of an amendment. If there is a significant change such as a decrease or deletion of a benefit, we will prepare a new contract and Certificate Of Coverage.**

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

F. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of abreach.

G. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**You may terminate the policy at any time with 30 days' prior written notice. Once the letter of termination is received, we adjust our systems to indicate the customer has terminated. We reconcile all billing for changes in enrollment within 60 days from the date of termination and return overpayments or request payments due. In most cases, terminations and billing reconciliations are completed within 30 days from the termination date.** **We may cancel or modify the policy if enrollment falls below the minimum established percentages, you fail to provide information needed to administer the plan or premiums are not paid within the grace period. We provide a notice of contract termination 30 days in advance.**

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different

time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

H. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			Noted.

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

I. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	We are agreeable to a mutual waiver provision.

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

J. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	All fully insured group policies are subject to regulation by the Nebraska Department of Insurance (DOI). Consequently, all group policies must be filed and approved by the DOI, before they can be sold in Nebraska. To accommodate the individual requirements of each prospective customer, we leave certain provisions bracketed (i.e., open) in our filed policies. However, there is no hold harmless provision in the insured contract and it is not one of those bracketed items. Since we assume the risk under an insurance contract, we do accept liability for those acts that arise out of our performance under the contract, to the extent that the customer does not contribute to the problem in some way.

1. GENERAL

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or

attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. **SELF-INSURANCE**

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

K. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Each party is responsible for bearing its own legal costs. We recognize the importance of cooperating with our customers when such issues, claims or actions arise. We would attempt to address such issues in a manner that strongly encourages full cooperation between the parties to the extent that such cooperation does not violate any applicable laws, create a breach of any duties or otherwise compromise the confidentiality of communications or information about issues, claims or actions.**

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

L. **ASSIGNMENT, SALE, OR MERGER**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We would agree that neither party can assign this contract, or any rights or obligations under this contract, to anyone without the other party's written consent. Notwithstanding, we need the ability to assign this contract, including all of our rights and obligations, to our affiliates; to an entity controlling, controlled by, or under common control with us; or a purchaser of all, or substantially all of our assets, subject to notice to the customer of the assignment. We need this discretion in the utilization of our sister companies. We cannot agree to have one customer have veto power over our business choice to assign the arrangement to a sister company, because that business decision affects our entire book of business.**

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

M. **CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Affiliation business is unique and each opportunity requires an analysis specific to that opportunity. Upon review of the available information, our organization determines our ability to meet the needs of the affiliation. A review of existing bylaws, requested services and funding, state regulations and historical experience of the affiliation will be included in our analysis.**

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

N. **FORCE MAJEURE**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

		X	**We encourage the State to use our filed and approved group policy and Certificate of Coverage. Any deviation to the terms and conditions of those documents could potentially require us to conduct a customer-specific filing with the DOI, which would have to be approved by the DOI prior to use. We would, however, agree to a force majeure condition, should such an event arise, with the understanding that the period of time our services shall be suspended shall equate to the period of time we are unable to perform due to the event, versus the length of the event itself.**

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

O. **CONFIDENTIALITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**We are compliant with the HIPAA regulations and continue to monitor the regulations to assure our ongoing compliance.**

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

P. **EARLY TERMINATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**You may terminate the policy at any time with 30 days' prior written notice. Once the letter of termination is received, we adjust our systems to indicate the customer has terminated. We reconcile all billing for changes in enrollment within 60 days from the date of termination and return overpayments or request payments due. In most cases, terminations and billing reconciliations are completed within 30 days from the termination date.** **We may cancel or modify the policy if enrollment falls below the minimum established percentages, you fail to provide information needed to administer the plan or premiums are not paid within the grace period. We provide a notice of contract termination 30 days in advance.**

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.
2. In the event of policy termination, either on or off policy anniversary date, Contractor will fully account for all reserves and return to The State any unused portion.
3. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
4. The State may terminate the contract immediately for the following reasons:
   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable; and,
   i. In the event funding is no longer available.

Q. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Upon termination, we will transfer all necessary information to the succeeding carrier or third-party administrator, within a reasonable time frame, in accordance with applicable state and federal law. If the customer desires more data, particularly historical claim files, we are willing to try to reach an agreement with the State and would require a hold harmless for the release of such information. There may be a charge for pulling several years of claim records. We are happy to discuss specific time frames for the delivery of information and are confident that we can reach a mutually satisfactory result.** **We confirm we will cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract; cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract; and as mentioned above, we will transfer all necessary information to the succeeding carrier or third-party administrator, within a reasonable time frame, in accordance with applicable state and federal law.**

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or

data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;

4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Please see our comments and alternatives below.**

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

Confirmed.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

Confirmed.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

Confirmed.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

Confirmed.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

Confirmed.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

Confirmed.

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

Please refer to the Subcontractor Listing for State of Nebraska, included in Section 12.

UnitedHealth Group Incorporated (UnitedHealth Group) and its affiliates manage their respective Shared Service Operations comprised of comprehensive processes and systems which support our customers across various markets and product platforms. Likewise, UnitedHealth Group closely manages various trusted third- party suppliers for their unique health care service delivery capabilities to support specific areas of our internal operations. As such, these Shared Service Operations are intended to leverage breadth and depth in our capabilities to ensure we excel on our customer commitments (i.e., cost, quality and performance, etc.) in health care delivery and health plan management.

The majority of the services we provide are performed by UnitedHealth Group personnel. Because of the scope and dynamic nature of our business, we are unable to commit to notifying the customer of every subcontractor we use.

Prior to selecting subcontractors, we complete a thorough review of their qualifications. Further, we will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

As mentioned above, the majority of the services we provide are performed by UnitedHealth Group personnel. Because of the scope and dynamic nature of our business, we are unable to commit to notifying the customer of every subcontractor we use.

Prior to selecting subcontractors, we complete a thorough review of their qualifications. Further, we will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

Confirmed.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

We are unable to agree to include these provisions in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**We are registered with the federal government to use the E-Verify system. Our company number in E-Verify is 438670. The Memo of Understanding was executed on August 9, 2011, and the first verification was initiated on September 1, 2011.**

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the RFP response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this RFP.

We confirm that our organization is currently operating in material compliance with all relevant federal and state laws and regulations relating to the services we are proposing.

We are unable to agree to include these provisions in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**It is not contemplated that works or inventions will be created by us on behalf of the State. Our services are universally provided to our entire book of business, and not created through a means that would pass title or ownership to any one customer.**

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	X		**This proposal is provided in response to a request to bid; information included in the proposal is to be used only in that context.** **It is not contemplated that works or inventions will be created by us on behalf of the State. Our services are universally provided to our entire book of business, and not created through a means that would pass title or ownership to any one customer.**

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We have included necessary deviations to RFP section III. Contractor Duties, G. Insurance Requirements, within our proposal.**

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

We are unable to make contractual commitments on behalf of our subcontractors, who are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

Even though subcontractors are not named as insureds under our policy, we require them to maintain adequate levels of insurance coverage and we will be responsible for services provided by our contractors to the same extent that we would have been, had we performed those services without the use of a contractor.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within three (3) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and three (3) years following termination or expiration of the contract.

Noted.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Noted.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

We have included necessary deviations to the liability limits of the insurance policies required herein within our proposal.

1. **WORKERS' COMPENSATION INSURANCE**
The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter.** The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

Noted.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**
The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

Noted.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

Noted.

We have included necessary deviations within the required insurance coverages detailed in the table below.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$1,000,000 per occurrence / $2,000,000 aggregate
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$3,000,000 per occurrence
PROFESSIONAL LIABILITY	
Professional liability (Medical Malpractice)	Limits consistent with Nebraska Medical Malpractice Cap
Qualification Under Nebraska Excess Fund	
All Other Professional Liability (Errors & Omissions)	$10,000,000 Per Claim / $20,000,000
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$2,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$2,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

Not confirmed. Our insurance policies are considered proprietary.

3. **EVIDENCE OF COVERAGE**

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Administrative Services
Employee Wellness and Benefits
Attn: Contract Manager 1526 K
Street, Suite 110
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the

name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

Noted.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

We have included necessary deviations to RFP section III. Contractor Duties, G. Insurance Requirements, within our proposal.

H. **ANTITRUST**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We are unable to agree to an automatic assignment of claims for overcharges resulting from third-party antitrust violations. These claims need to be evaluated on a case-by-case basis. Further, we take appropriate steps to monitor such situations and to prevent them from occurring. We have a corporate compliance program that includes policies relating to antitrust issues. We advise our employees of the necessity to comply with the law, provide them with ongoing education about legal requirements, and instruct them to contact our legal services staff, if questions arise. In addition, our legal and compliance staff analyzes potential business ventures and subcontracts with vendors, with an emphasis on minimizing antitrust exposure. Network physician and other health care professional agreements are drafted or reviewed by our legal services department, as part of our effort to comply with legal requirements.**

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

I. **CONFLICT OF INTEREST**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**To the best of our knowledge, we have no relationships with the State to disclose at this time.**

By submitting a proposal, bidder certifies that there does not now exist a relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this RFP or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or an appearance of conflict of interest.

The bidder certifies that it will not knowingly employ any individual known by bidder to have a conflict of interest.

The Parties shall not knowingly, for a period of two years after execution of the contract, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J. **ADVERTISING**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**We confirm we will not use the State's name or the name of its affiliates in any solicitation or promotional materials without first obtaining written consent from the State.**

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

K. **DISASTER RECOVERY/BACK UP PLAN**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We have an Enterprise Resiliency & Response program that minimizes customer impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines. Our plans are developed to address all natural and man-made disasters (e.g., hurricanes, floods, fires, terrorism attacks and disease pandemics). The program focuses on critical business functions and systems and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of our operations and assets.** **An overview document is attached which describes the governance, strategy and controls for the entire program. This document is not intended to replace the business continuity or disaster recovery plan review, but does provide assurance that we have a well-defined program in place to ensure customer impact is minimized during a disaster.** **Due to the sensitive nature of the information, our complete business continuity and disaster recovery plans are considered proprietary and confidential. For audit purposes, the plans may be viewed in a controlled environment with our subject matter experts, who will be made available to answer questions. The plans may not be copied or removed after the meeting. This policy is in place to protect not only our operations and our employees, but also the security, integrity and confidentiality of protected information.**

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

L. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We confirm that we maintain a drug-free workplace environment to ensure worker safety and workplace integrity. While our policies and procedures are considered proprietary, we are happy to provide a drug-free workplace statement of policy at any time upon request by the State.**

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.
Confirmed.

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

Confirmed.

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices should be sent to Department of Administrative Services, Employee Wellness and Benefits, 1526 K Street, Suite 110, Lincoln, NE 68508.

The invoice must contain the State's Account number and or ID number and the Coverage Period being billed. The invoice must list each plan and rates for the plans. Premiums are deducted via payroll on a Bi-Weekly and/or Monthly basis. After the close of business each month the total premiums deducted are paid to the Contractor via ACH payment. Premiums are not paid in advance. Example, August premiums would not be paid to the Contractor until after close of business on August 31st. In the example above, the 45 days starts on September 1st. As premiums are sent via ACH an Excel or PDF Report will be generated and provided to the Contractor by the State as backup documentation for the premiums paid. The Report is produced manually and date of completion may vary from month to month.

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the

State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**The inspection and testing of our facilities and processes for producing materials is not applicable to the products and services included in our quote. Our services are not durable goods, but administration of which "agreement or compliance" can be assessed through audit rather than inspection.** **We will make available to the State, or a mutually acceptable designee, relevant information reasonably necessary for you to perform planning, administration and financial functions, except as may be prohibited by law or by third-party contract.** **Under a fully insured arrangement, we do not support customer audits of our claim records, since we assume the medical plan administration risk.**

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. (Neb. Rev. Stat. Section 73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

Confirmed.

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Upon any termination of the group policy, the State shall be and shall remain liable to us for the payment of any and all premiums that are unpaid at the time of termination, including a pro rata fee for any period this policy was in force during the grace period preceding the termination.**

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by

the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

The State of Nebraska ("the State"), through the Department of Administrative Services, currently offers Long Term Disability (LTD) to State employees. Beginning July 1, 2019, the State will also offer Short Term Disability (STD). The State is seeking proposals from qualified disability carriers to provide fully insured STD and LTD benefits, for the approximate 15,670 eligible state permanent and temporary employees, effective July 1, 2019.

The purpose of this RFP is to select a Contractor to provide all necessary and required services including staffing, systems and other critical components, which advances early return to work, notifications, insurance, fully insured premiums, claims adjudication, claims payment, customer service, underwriting, consulting, and reports for the State of Nebraska for:

1. Short-Term Disability (STD) plan (100% paid by the employee/post tax deductions), and
2. Long Term Disability (LTD) plan (100% paid by the employee/post tax deductions).

This RFP does not include group term life insurance, accidental death and dismemberment, optional term life insurance or any other employee benefits program.

The Contractor must be able to offer both STD and LTD.

Noted.

B. CURRENT AND FUTURE ENVIRONMENT

The current LTD benefits include only one (1) income option with four (4) qualifying (elimination period) options. A detailed description of age-banded premium rate for current LTD benefit options can be found in the Attachment B: Current Long Term Disability Benefits.

A summary of reports can be found in the following attachments:

Attachment C Closed Claims Listing for Group
Attachment D Open Claims Report
Attachment E Group Paid Basis Report

Coverage is 100% voluntary, with employees covering the full cost of coverage. Premium rates are age-banded for both permanent and temporary employees. The State maintains the same LTD benefit options for employees under the labor contract as it does for those not under the labor contract. Of the State's eligible permanent and temporary employees, 6,375 are currently enrolled in one of the current LTD plan options.

Effective July 1, 2019, the State will provide a fully insured, full service administration, and 100% voluntary STD plan to the same population of permanent and temporary employees. The new STD plan will provide 1st day accident coverage, 8th day illness coverage, and will pay benefits up to six (6) months with 60% income option. Employees will not be required to exhaust their leave balances to begin receiving STD benefit payments. The LTD benefit offering will have one elimination period of six (6) months with 60% income option.

Noted.

C. ADMINISTRATION REQUIRMENTS

This section contains specific work requirements related to the administration of the employee disability plans. The table identifies whether the State of Nebraska or the Contractor will perform the service. Contractor must provide the services, at a minimum, identified under the respective heading and coordinate the transition of cases that progress from short-term to long-term durations.

Please refer to our responses under the STD and LTD Contractor heading.

We confirm we will coordinate the transition of cases that progress from short-term to long-term durations.

Responsibility	State of Nebraska	STD and LTD Contractor
1. ENROLLMENT and ELIGIBILITY	A. Collects contributions from employees. B. Determines eligibility in all cases and maintains a database of enrolled employees.	
2. CUSTOMER SERVICE	A. Assists agencies and participants with eligibility and enrollment issues. B. Monitors the service agreements and insured contracts.	D. Assists participants and agencies with claims issues. **Confirmed.** E. Staffs a customer service department that provides telephone support to members via a toll free number. **Confirmed.**

Responsibility	State of Nebraska	STD and LTD Contractor
	C. Monitors carrier's performance and reviews customer complaints.	F. Maintains telephone technology for the hearing and visually impaired. **Confirmed.** G. Responds to participant questions on enrollment, claims and benefits. **Confirmed.** H. Handles problems and complaints initially and pursues all other inquiries in a timely fashion and advises State of NE of escalated issues and recurring patterns. **We measure and track life and disability complaints and any procedures created as a result. However, this information is not shared with the policyholder.** **The client manager and strategic client executive share authority for issue resolution and escalation.** **Based on the type and severity of the escalation, the client manager reaches out to internal leadership resources within UnitedHealthcare to assist in resolution. During this process, the client manager involves the strategic client executive through regular conversations or review of Issue/Opportunity logs.** **We operate on a single platform that tracks turnaround time performance by customer across all departments. We review issue resolution data on a weekly basis with account management teams to ensure service level agreements are met.**

3.COMMUNICATIONS	A.	Approves all communication materials prior to distribution.	B.	Develops enrollment materials. **Confirmed.**
			C.	Develops and produces a standard benefit description form and also makes it available in an electronic format. **Confirmed.**
			D.	Develops benefits booklet (Summary Plan Description (SPD)/ Certificate of Coverage). **As this is a fully insured quote, we will provide the State with a certificate of coverage, rather than a summary plan descriptions (SPD), which is a self-funded document.**
			E.	Works with State of Nebraska communications personnel. **Confirmed.**
			F.	Provides content for direct employee communications at the State's request. **Confirmed.**
			G.	Provides assistance to State at Annual Open Enrollment meetings. **Confirmed.**
4. CLAIMS PROCESSING			A.	Processes all claims. **Confirmed.**
			B.	Maintains a process for the correction of under and over payments. **Confirmed.**
			C.	Issues W-2 forms to employees. **Confirmed.**
			D.	Withhold Medicare taxes from the disabled employee's disability benefits and remits them to the federal government. **Confirmed.**
			E.	Remits the State's portion of Medicare tax (from a State Medicare matching Fund) to the federal government. **Confirmed.**

5. CLAIM MANAGEMENT		A. Maintains and provides effective case management and disability management programs. **Confirmed.** B. Provides Return to Work services. **Confirmed.** C. Identifies and reports fraud. **Confirmed.**
6. COORDINATION OF BENEFITS		A. Coordinates with other programs that provide Deductible Income (offset income) when applicable. **Confirmed.**
7. COORDINATION WITH OTHER INSURANCE COMPANIES OR VENDORS		A. Coordinates with State's online enrollment vendor **Not applicable.**
8. REPORTING		A. Monthly and quarterly claims paid/denied reports must be available no later than the end of the month following the close of the period in question. **Confirmed. You may access disability insurance reports at any time. Our reports are available online and the data is updated nightly, so you choose the frequency that works best for you.** **In our standard disability claim reports, we include:** ■ **Benefits paid** ■ **Claims by division** ■ **Claim totals** **We provide ad hoc reports upon request.**

Responsibility	State of Nebraska	STD and LTD Contractor
		B. A year-end financial accounting for the program within 60 days of the contract anniversary date. **Confirmed.**
9. MISCELLANEOUS		A. Attends quarterly meetings with State of Nebraska and other meetings as requested by the State at insurance company expense. **Confirmed.** B. Provides proposed fee changes by January 1 for the subsequent July 1 unless otherwise requested by the State. **Confirmed.** C. Advises State of any new regulatory compliance issues that affect the State's account. **Confirmed.**

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Noted.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

Noted.

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "RFP for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP, agrees to the Terms and Conditions stated in this RFP unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

We confirm we maintain a drug-free environment.

We make every effort to ensure that our proposal reflects the same benefits described in our contract. Our proposal provides a summary of benefits and definitions; whereas our contract provides in-depth details and is the document that will rule in a discrepancy.

We have included deviations to specific requirements within II. Terms and Conditions of the State's RFP.

The RFP for Contractual Services form must be signed using an indelible method (not electronically) and returned per the schedule of events in order to be considered for an award.
Noted.

Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

Noted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

Noted.

Further, Sections II through VII must be completed and returned with the proposal response.

Noted.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

UnitedHealth Group has its registered and principal executive offices at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343. UnitedHealth Group's telephone number is (952) 936-1300 or (800) 328-5979, and the fax number is (952) 936-7430. The website address is www.unitedhealthgroup.com.

UnitedHealth Group, a Delaware corporation originally organized in Minnesota in January 1977 and reincorporated in Delaware on July 1, 2015, is the ultimate controlling entity in the insurance holding company system. It was formerly named United HealthCare Corporation.

UnitedHealthcare Insurance Company, the legal entity with which we quote our fully insured business, is a C-Corporation.

UnitedHealthcare Insurance Company is located at 185 Asylum Street, Hartford, Connecticut 06103-0450.

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

Please refer to the 2017 UHIC Audited Financial Statements, included in Section 12.

James F. Bedard
185 Asylum Street, Hartford Connecticut 06103
(860) 702-6811
james_f_bedard@uhc.com

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

Not applicable, as we are a publically-held corporation.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

As a result of the nature of our industry, we are periodically the subject of routine, random and other investigations and audits that relate to our contracts with public bodies. Some of these reviews are ongoing, and the outcome cannot be predicted. None of these matters would in any way impede our ability to meet our obligations under our contract.

We can share some general comments about our litigation history; however, for confidentiality reasons, we are unwilling to disclose detailed information.

In providing health benefit services and claims administration services, we have been involved in litigation. The majority of suits are brought by those seeking to challenge benefit decisions or to allege liability for malfeasance of some nature.

Our law department conducts an initial assessment of each suit filed against us and recommends whether the matter should be resolved or referred to local counsel for defense. Many of the suits against the company are resolved by settlement or by dispositive motions. None has had a known, material impact on our businesses or practices.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

Noted.

c. **CHANGE OF OWNERSHIP**

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

There are no pending or anticipated ownership changes. As a public company, our shares trade every day, but the large owners have generally been stable and no one has (or is expected to) purchase a 10 percent or greater position in the company.

d. **OFFICE LOCATION**

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

All claims are processed at our South Portland, Maine office. Our call center is also located in South Portland, Maine.

The person with overall responsibility for your account is your strategic client executive, Jane Perez.

All correspondence should be sent to Post Office Box 7466, Portland, Maine 04112-7466.

The physical address is 300 Southborough Drive, South Portland, Maine 04106.

e. **RELATIONSHIPS WITH THE STATE**

The bidder should describe any dealings with the State over the previous three (3) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

In the previous 3 years, UnitedHealthcare has the following contracts with the State of Nebraska

51597 04 Effective 7/1/12 to 6/30/18 – State Employee Medical and Pharmacy Administration

77103 04 Effective 7/1/18 to 6/30/20- State Employee Medical and Pharmacy Administration

64226 04 Effective 7/1/15 to 12/31/16 – Medicaid

71163 04 Effective 1/1/17 to 12/31/21 – Medicaid

f. **BIDDER'S EMPLOYEE RELATIONS TO STATE**

If any Party named in the bidder's proposal response is or was an employee of the State within the past twenty four (24) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

To the best of our knowledge, we are not aware of any lobbying that has occurred in connection with this procurement, nor are we aware of any gifts or other items of value have been provided to the State officials or employees.

g. **CONTRACT PERFORMANCE**

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.

If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

We are not aware of any cases where we were awarded work and did not complete it.

Contractual arrangements with our customers are confidential during the agreement period, as well as following termination.

h. **SUMMARY OF BIDDER'S CORPORATE EXPERIENCE**

Contractor should have a minimum of seven (7) years of STD insurance and claims administration experience and a minimum of seven (7) years of LTD insurance and claims administration experience.

Confirmed.

The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

- a) The time period of the project;
- b) The scheduled and actual completion dates;
- c) The Contractor's responsibilities;
- d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- e) Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

Travis County reference contact:
Shannon Steele
Travis County Benefits Manager
Direct - 512.854.6046
Benefits line - 512.854.0404
Shannon.Steele@traviscountytx.gov

Travis County has UHC's medical and Basic Life/AD&D for 5,012 employees since 10/1/2016. We are responsible for administration of the contract, claims payment and reporting. Additionally, we negotiate

contract renewal rates and provide client service on issues that might arise throughout the year. This contract renews annually and runs for a period of 5 years before it requires re-bidding. The length of the implementation was 61 days and was performed as the prime contractor. Please see the implementation checklist for reference for all responsibilities performed and a standard timeline of 30-45 days.

Louisiana State University contact:
Amy A. Kirby, M.S.
Office of Human Resource Management
110 Thomas Boyd Hall| Baton Rouge, LA 70803
O: 225.578.8397| M: 225.578.8200 | F: 225.578.6571
Email: aamoroso@lsu.edu

LSU has UHC's medical, voluntary life, voluntary LTD, voluntary dental, voluntary vision, Critical Illness and Accident contract for 8,226 employees since 1/1/2015. UHC was awarded the contract in mid-July 2014. The contract was awarded based on overall pricing of the package of benefits, streamlined account management and an implementation credit to be used towards their ben admin system. They have been inforce since then and have just gone through their third renewal. The length of the implementation was 84 days for 7 lines of coverage and was completed prior to open enrollment. The work was performed as the prime contractor. Please see the implementation checklist for reference for all responsibilities performed and a standard timeline of 30-45 days.

Jackson Public Schools contact:
Sharolyn Miller
Chief Financial Officer
Jackson Public School District
(601) 960-8801 main
smiller@jackson.k12.ms.us

Jackson Public School has UHC's vision, Life and LTD for 4,310 employees since 2/1/15. The Vision was implemented first and then we implemented Life/LTD for 1/1/16. They just renewed for 1/1/19 for 36 months. The vision implementation was handled in 21 days and the Life and LTD was roughly 45 days and was performed as the prime contractor. Please see the implementation checklist for reference for all responsibilities performed and a standard timeline of 30 to 45 days.

ii. Contractor and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as Subcontractor projects.
Noted.

iii. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, Subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.
UnitedHealth Group provides most of our core health care delivery services through our proprietary capabilities within our family of companies. This enables us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

UnitedHealth Group directly maintains trusted relationships with a variety of external sourcing partners managed through required Master Service and Business Associate Agreements in addition to a disciplined and focused approach on contract compliance, performance management and information security.

UnitedHealth Group's trusted relationships with our sourcing partners are managed within a shared service structure supporting a variety of customers, products and markets and are not typically dedicated to a specific customer. Those sourcing partners who may touch your account would be identified based on your benefit plan structure, our internal business processes and your expectations.

i. **SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH**
The bidder should present a detailed description of its proposed approach to the management of the project.

You will be supported by a multi-functional account management team who will be well-trained in your benefit program and cultural requirements. The account management team, led by the strategic client executive, Jane Perez, contains representation from all disciplines specifically required to serve your needs.

The account management team assigned to your account delivers on our promise to maximize the investment that you make in health care. The team's top priority is building a successful partnership with you to address your overall goals and coordinate day-to-day activities. The team is your point of contact for all aspects of administration, claims, underwriting, contracts, eligibility, billing and reporting, and works to ensure that all of your needs are met.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

Please refer to the State of Nebraska – Management and Service Team, included in Section 12, which includes the requested information. Please note members of the account management team report to varied department managers – including client services, operations, implementation, financial, computer system, etc. – based on their individual role.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.

Please see the Jane Perez Resume, Jelena Edwards Resume, Clifton Sumrall Resume, Ann Marie Strought Resume, Kim Blais Resume, and Travis Jordan Resume, each of which are included in Section 12.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Noted.

j. **SUBCONTRACTORS**
If the bidder intends to Subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the Subcontractor(s);

ii. specific tasks for each Subcontractor(s);
iii. percentage of performance hours intended for each Subcontract; and
iv. total percentage of Subcontractor(s) performance hours.

Please refer to the Subcontractor Listing for State of Nebraska, included in Section 12.

UnitedHealth Group and its affiliates manage their respective Shared Service Operations comprised of comprehensive processes and systems which support our customers across various markets and product platforms. Likewise, UnitedHealth Group closely manages various trusted 3rd party suppliers for their unique healthcare service delivery capabilities to support specific areas of our internal operations. As such, these Shared Service Operations are intended to leverage breadth and depth in our capabilities to ensure we excel on our customer commitments (i.e. cost, quality and performance, etc.) in health care delivery and health plan management.

3. **TECHNICAL APPROACH**

The technical approach section of the Technical Proposal should consist of the following subsections:

a. Understanding of the project requirements;
b. Proposed development approach;
c. Technical considerations;
d. Detailed project work plan; and
e. Deliverables and due dates.

Throughout the implementation process, our goal is to build a successful partnership with you. Implementation begins with your Client Manager, Jelena Edwards, who is responsible for facilitating the implementation of your account, by working closely with our internal Implementation Manager.

Jelena schedules an implementation meeting to expedite a smooth benefit plan transition. At this meeting, the following is discussed:

- **Roles and Responsibilities: Review of key contacts and accountabilities for implementation**
- **Implementation Timeline: Review of the key milestones and deadlines for case installation, including meeting schedules**
- **Products and Services: Detailed discussion of what we will provide, including a complete description of the benefit plan(s)**
- **Eligibility and Reporting: Description of eligibility and financial reporting needs**
- **Enrollment Strategy and Communication Materials: Enrollment meeting strategy and resources, including member materials like enrollment forms and benefit summaries**

After the initial meeting, Jelena completes the detailed steps of the implementation, working with experts from claims, customer service, eligibility, contracts, billing, reporting and underwriting.

Jelena is in frequent contact with you throughout the implementation process to ensure that the following activities occur accurately and on time:

- **Benefit Design: We load the benefit design information into the appropriate systems in advance of the effective date. Claim and customer service systems are fully tested.**

- **Billing: Our billing systems are set up to process monthly payments and maintain records so we can produce a variety of financial reports.**
- **Claims: Claims systems are set up to accurately pay claims.**
- **Customer Service: The call center can answer questions about coverage during the open enrollment period and beyond.**
- **Contract Administration: Contracts are drafted and submitted to you for review and final approval.**
- **Communication Materials: We will produce enrollment materials, such as enrollment/change forms and beneficiary forms.**

Please refer to the Sample Implementation Timeline, included in the Attachments section of the RFP, for a detailed breakdown of tasks, suggested timeline, and responsible parties.

VII. COST PROPOSAL REQUIREMENTS

This section describes the requirements to be addressed by bidders in preparing the State's Cost Sheet. The bidder must use the State's Cost Sheet. The bidder should submit the State's Cost Sheet in accordance with Section I Submission of Proposal.

THE STATE'S COST SHEET AND ANY OTHER COST DOCUMENT SUBMITTED WITH THE PROPOSAL SHALL NOT BE CONSIDERED CONFIDENTIAL OR PROPRIETARY AND IS CONSIDERED A PUBLIC RECORD IN THE STATE OF NEBRASKA AND WILL BE POSTED TO A PUBLIC WEBSITE.

A. COST SHEET

This summary shall present the total fixed price to perform all of the requirements of the RFP. The bidder must include details in the State's Cost Sheet supporting any and all costs.

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

Noted.

B. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the RFP. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Noted.

Section 6

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Please see our comments and alternatives below.**

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

Confirmed.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

Confirmed.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

Confirmed.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

Confirmed.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

Confirmed.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

Confirmed.

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

Please refer to the Subcontractor Listing for State of Nebraska, included in Section 12.

UnitedHealth Group Incorporated (UnitedHealth Group) and its affiliates manage their respective Shared Service Operations comprised of comprehensive processes and systems which support our customers across various markets and product platforms. Likewise, UnitedHealth Group closely manages various trusted third- party suppliers for their unique health care service delivery capabilities to support specific areas of our internal operations. As such, these Shared Service Operations are intended to leverage breadth and depth in our capabilities to ensure we excel on our customer commitments (i.e., cost, quality and performance, etc.) in health care delivery and health plan management.

The majority of the services we provide are performed by UnitedHealth Group personnel. Because of the scope and dynamic nature of our business, we are unable to commit to notifying the customer of every subcontractor we use.

Prior to selecting subcontractors, we complete a thorough review of their qualifications. Further, we will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

As mentioned above, the majority of the services we provide are performed by UnitedHealth Group personnel. Because of the scope and dynamic nature of our business, we are unable to commit to notifying the customer of every subcontractor we use.

Prior to selecting subcontractors, we complete a thorough review of their qualifications. Further, we will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

Confirmed.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

We are unable to agree to include these provisions in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**We are registered with the federal government to use the E-Verify system. Our company number in E-Verify is 438670. The Memo of Understanding was executed on August 9, 2011, and the first verification was initiated on September 1, 2011.**

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the RFP response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this RFP.

We confirm that our organization is currently operating in material compliance with all relevant federal and state laws and regulations relating to the services we are proposing.

We are unable to agree to include these provisions in every subcontract, as our subcontractors are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**It is not contemplated that works or inventions will be created by us on behalf of the State. Our services are universally provided to our entire book of business, and not created through a means that would pass title or ownership to any one customer.**

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must

guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	X		**This proposal is provided in response to a request to bid; information included in the proposal is to be used only in that context.** **It is not contemplated that works or inventions will be created by us on behalf of the State. Our services are universally provided to our entire book of business, and not created through a means that would pass title or ownership to any one customer.**

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We have included necessary deviations to RFP section III. Contractor Duties, G. Insurance Requirements, within our proposal.**

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

We are unable to make contractual commitments on behalf of our subcontractors, who are engaged across our book of business, rather than for one specific customer. However, we will be responsible for services provided by our subcontractors to the same extent that we would have been, had we performed those services without the use of a subcontractor.

Even though subcontractors are not named as insureds under our policy, we require them to maintain adequate levels of insurance coverage and we will be responsible for services provided by our contractors to the same extent that we would have been, had we performed those services without the use of a contractor.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within three (3) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and

three (3) years following termination or expiration of the contract.

Noted.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Noted.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

We have included necessary deviations to the liability limits of the insurance policies required herein within our proposal.

1. **WORKERS' COMPENSATION INSURANCE**

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter.** The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

Noted.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

Noted.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

Noted.

We have included necessary deviations within the required insurance coverages detailed in the table below.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$1,000,000 per occurrence / $2,000,000 aggregate
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	

Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$3,000,000 per occurrence
PROFESSIONAL LIABILITY	
Professional liability (Medical Malpractice)	Limits consistent with Nebraska Medical Malpractice Cap
Qualification Under Nebraska Excess Fund	
All Other Professional Liability (Errors & Omissions)	$10,000,000 Per Claim / $20,000,000
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$2,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$2,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

Not confirmed. Our insurance policies are considered proprietary.

3. **EVIDENCE OF COVERAGE**

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Administrative Services Employee
Wellness and Benefits
Attn: Contract Manager 1526 K Street,
Suite 110
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

Noted.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

We have included necessary deviations to RFP section III. Contractor Duties, G. Insurance Requirements, within our proposal.

H. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We are unable to agree to an automatic assignment of claims for overcharges resulting from third-party antitrust violations. These claims need to be evaluated on a case-by-case basis. Further, we take appropriate steps to monitor such situations and to prevent them from occurring. We have a corporate compliance program that includes policies relating to antitrust issues. We advise our employees of the necessity to comply with the law, provide them with ongoing education about legal requirements, and instruct them to contact our legal services staff, if questions arise. In addition, our legal and compliance staff analyzes potential business ventures and subcontracts with vendors, with an emphasis on minimizing antitrust exposure. Network physician and other health care professional agreements are drafted or reviewed by our legal services department, as part of our effort to comply with legal requirements.**

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

I. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**To the best of our knowledge, we have no relationships with the State to disclose at this time.**

By submitting a proposal, bidder certifies that there does not now exist a relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this RFP or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or an appearance of conflict of interest.

The bidder certifies that it will not knowingly employ any individual known by bidder to have a conflict of interest.

The Parties shall not knowingly, for a period of two years after execution of the contract, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			**We confirm we will not use the State's name or the name of its affiliates in any solicitation or promotional materials without first obtaining written consent from the State.**

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

K. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We have an Enterprise Resiliency & Response program that minimizes customer impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines. Our plans are developed to address all natural and man-made disasters (e.g., hurricanes, floods, fires, terrorism attacks and disease pandemics). The program focuses on critical business functions and systems and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of our operations and assets.** **An overview document is attached which describes the governance, strategy and controls for the entire program. This document is not intended to replace the business continuity or disaster recovery plan review, but does provide assurance that we have a well-defined program in place to ensure customer impact is minimized during a disaster.** **Due to the sensitive nature of the information, our complete business continuity and disaster recovery plans are considered proprietary and confidential. For audit purposes, the plans may be viewed in a controlled environment with our subject matter experts, who will be made available to answer questions. The plans may not be copied or removed after the meeting. This policy is in place to protect not only our operations and our employees, but also the security, integrity and confidentiality of protected information.**

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

L. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**We confirm that we maintain a drug-free workplace environment to ensure worker safety and workplace integrity. While our policies and procedures are considered proprietary, we are happy to provide a drug-free workplace statement of policy at any time upon request by the State.**

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

IV. PAYMENT

A. **PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)**

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.
Confirmed.

B. **TAXES (Statutory)**

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

Confirmed.

C. **INVOICES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices should be sent to Department of Administrative Services, Employee Wellness and Benefits, 1526 K Street, Suite 110, Lincoln, NE 68508.

The invoice must contain the State's Account number and or ID number and the Coverage Period being billed. The invoice must list each plan and rates for the plans. Premiums are deducted via payroll on a Bi-Weekly and/or Monthly basis. After the close of business each month the total premiums deducted are paid to the Contractor via ACH payment. Premiums are not paid in advance. Example, August premiums would not be paid to the Contractor until after close of business on August 31st. In the example above, the 45 days starts on September 1st. As premiums are sent via ACH an Excel or PDF Report will be generated and provided to the Contractor by the State as backup documentation for the premiums paid. The Report is produced manually and date of completion may vary from month to month.

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. **INSPECTION AND APPROVAL**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

		X	**The inspection and testing of our facilities and processes for producing materials is not applicable to the products and services included in our quote. Our services are not durable goods, but administration of which "agreement or compliance" can be assessed through audit rather than inspection.** **We will make available to the State, or a mutually acceptable designee, relevant information reasonably necessary for you to perform planning, administration and financial functions, except as may be prohibited by law or by third-party contract.** **Under a fully insured arrangement, we do not support customer audits of our claim records, since we assume the medical plan administration risk.**

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. (Neb. Rev. Stat. Section 73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

Confirmed.

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Upon any termination of the group policy, the State shall be and shall remain liable to us for the payment of any and all premiums that are unpaid at the time of termination, including a pro rata fee for any period this policy was in force during the grace period preceding the termination.**

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent

upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.
Confirmed.

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

Confirmed.

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices should be sent to Department of Administrative Services, Employee Wellness and Benefits, 1526 K Street, Suite 110, Lincoln, NE 68508.

The invoice must contain the State's Account number and or ID number and the Coverage Period being billed. The invoice must list each plan and rates for the plans. Premiums are deducted via payroll on a Bi-Weekly and/or Monthly basis. After the close of business each month the total premiums deducted are paid to the Contractor via ACH payment. Premiums are not paid in advance. Example, August premiums would not be paid to the Contractor until after close of business on August 31st. In the example above, the 45 days starts on September 1st. As premiums are sent via ACH an Excel or PDF Report will be generated and provided to the Contractor by the State as backup documentation for the premiums paid. The Report is produced manually and date of completion may vary from month to month.

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

		X	**The inspection and testing of our facilities and processes for producing materials is not applicable to the products and services included in our quote. Our services are not durable goods, but administration of which "agreement or compliance" can be assessed through audit rather than inspection.** **We will make available to the State, or a mutually acceptable designee, relevant information reasonably necessary for you to perform planning, administration and financial functions, except as may be prohibited by law or by third-party contract.** **Under a fully insured arrangement, we do not support customer audits of our claim records, since we assume the medical plan administration risk.**

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. (Neb. Rev. Stat. Section 73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

Confirmed.

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		X	**Upon any termination of the group policy, the State shall be and shall remain liable to us for the payment of any and all premiums that are unpaid at the time of termination, including a pro rata fee for any period this policy was in force during the grace period preceding the termination.**

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent

upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
X			

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

The State of Nebraska ("the State"), through the Department of Administrative Services, currently offers Long Term Disability (LTD) to State employees. Beginning July 1, 2019, the State will also offer Short Term Disability (STD). The State is seeking proposals from qualified disability carriers to provide fully insured STD and LTD benefits, for the approximate 15,670 eligible state permanent and temporary employees, effective July 1, 2019.

The purpose of this RFP is to select a Contractor to provide all necessary and required services including staffing, systems and other critical components, which advances early return to work, notifications, insurance, fully insured premiums, claims adjudication, claims payment, customer service, underwriting, consulting, and reports for the State of Nebraska for:

1. Short-Term Disability (STD) plan (100% paid by the employee/post tax deductions), and
2. Long Term Disability (LTD) plan (100% paid by the employee/post tax deductions).

This RFP does not include group term life insurance, accidental death and dismemberment, optional term life insurance or any other employee benefits program.

The Contractor must be able to offer both STD and LTD.

Noted.

B. CURRENT AND FUTURE ENVIRONMENT

The current LTD benefits include only one (1) income option with four (4) qualifying (elimination period) options. A detailed description of age-banded premium rate for current LTD benefit options can be found in the Attachment B: Current Long Term Disability Benefits.

A summary of reports can be found in the following attachments:

Attachment C Closed Claims Listing for Group
Attachment D Open Claims Report
Attachment E Group Paid Basis Report

Coverage is 100% voluntary, with employees covering the full cost of coverage. Premium rates are age-banded for both permanent and temporary employees. The State maintains the same LTD benefit options for employees under the labor contract as it does for those not under the labor contract. Of the State's eligible permanent and temporary employees, 6,375 are currently enrolled in one of the current LTD plan options.

Effective July 1, 2019, the State will provide a fully insured, full service administration, and 100% voluntary STD plan to the same population of permanent and temporary employees. The new STD plan will provide 1st day accident coverage, 8th day illness coverage, and will pay benefits up to six (6) months with 60% income option. Employees will not be required to exhaust their leave balances to begin receiving STD benefit payments. The LTD benefit offering will have one elimination period of six (6) months with 60% income option.

Noted.

C. ADMINISTRATION REQUIRMENTS

This section contains specific work requirements related to the administration of the employee disability plans. The table identifies whether the State of Nebraska or the Contractor will perform the service. Contractor must provide the services, at a minimum, identified under the respective heading and coordinate the transition of cases that progress from short-term to long-term durations.

Please refer to our responses under the STD and LTD Contractor heading.

We confirm we will coordinate the transition of cases that progress from short-term to long-term durations.

Responsibility	State of Nebraska	STD and LTD Contractor

1. ENROLLMENT and ELIGIBILITY	A.	Collects contributions from employees.		
	B.	Determines eligibility in all cases and maintains a database of enrolled employees.		
2. CUSTOMER SERVICE	A.	Assists agencies and participants with eligibility and enrollment issues.	D.	Assists participants and agencies with claims issues. **Confirmed.**
	B.	Monitors the service agreements and insured contracts.	E.	Staffs a customer service department that provides telephone support to members via a toll free number. **Confirmed.**

Responsibility	State of Nebraska	STD and LTD Contractor
	C. Monitors carrier's performance and reviews customer complaints.	F. Maintains telephone technology for the hearing and visually impaired. **Confirmed.** G. Responds to participant questions on enrollment, claims and benefits. **Confirmed.** H. Handles problems and complaints initially and pursues all other inquiries in a timely fashion and advises State of NE of escalated issues and recurring patterns. **We measure and track life and disability complaints and any procedures created as a result. However, this information is not shared with the policyholder.** **The client manager and strategic client executive share authority for issue resolution and escalation.** **Based on the type and severity of the escalation, the client manager reaches out to internal leadership resources within UnitedHealthcare to assist in resolution. During this process, the client manager involves the strategic client executive through regular conversations or review of Issue/Opportunity logs.** **We operate on a single platform that tracks turnaround time performance by customer across all departments. We review issue resolution data on a weekly basis with account management teams to ensure service level agreements are met.**

3.COMMUNICATIONS	A.	Approves all communication materials prior to distribution.	B.	Develops enrollment materials. **Confirmed.** C. Develops and produces a standard benefit description form and also makes it available in an electronic format. **Confirmed.** D. Develops benefits booklet (Summary Plan Description (SPD)/ Certificate of Coverage). **As this is a fully insured quote, we will provide the State with a certificate of coverage, rather than a summary plan descriptions (SPD), which is a self-funded document.** E. Works with State of Nebraska communications personnel. **Confirmed.** F. Provides content for direct employee communications at the State's request. **Confirmed.** G. Provides assistance to State at Annual Open Enrollment meetings. **Confirmed.**
4. CLAIMS PROCESSING			A.	Processes all claims. **Confirmed.** B. Maintains a process for the correction of under and over payments. **Confirmed.** C. Issues W-2 forms to employees. **Confirmed.** D. Withhold Medicare taxes from the disabled employee's disability benefits and remits them to the federal government. **Confirmed.** E. Remits the State's portion of Medicare tax (from a State Medicare matching Fund) to the federal government. **Confirmed.**

5. CLAIM MANAGEMENT		A. Maintains and provides effective case management and disability management programs. **Confirmed.** B. Provides Return to Work services. **Confirmed.** C. Identifies and reports fraud. **Confirmed.**
6. COORDINATION OF BENEFITS		A. Coordinates with other programs that provide Deductible Income (offset income) when applicable. **Confirmed.**
7. COORDINATION WITH OTHER INSURANCE COMPANIES OR VENDORS		A. Coordinates with State's online enrollment vendor **Not applicable.**
8. REPORTING		A. Monthly and quarterly claims paid/denied reports must be available no later than the end of the month following the close of the period in question. **Confirmed. You may access disability insurance reports at any time. Our reports are available online and the data is updated nightly, so you choose the frequency that works best for you.** **In our standard disability claim reports, we include:** ■ **Benefits paid** ■ **Claims by division** ■ **Claim totals** **We provide ad hoc reports upon request.**

Responsibility	State of Nebraska	STD and LTD Contractor
		B. A year-end financial accounting for the program within 60 days of the contract anniversary date. **Confirmed.**
9. MISCELLANEOUS		A. Attends quarterly meetings with State of Nebraska and other meetings as requested by the State at insurance company expense. **Confirmed.** B. Provides proposed fee changes by January 1 for the subsequent July 1 unless otherwise requested by the State. **Confirmed.** C. Advises State of any new regulatory compliance issues that affect the State's account. **Confirmed.**

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Noted.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

Noted.

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "RFP for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP, agrees to the Terms and Conditions stated in this RFP unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

We confirm we maintain a drug-free environment.

We make every effort to ensure that our proposal reflects the same benefits described in our contract. Our proposal provides a summary of benefits and definitions; whereas our contract provides in-depth details and is the document that will rule in a discrepancy.

We have included deviations to specific requirements within II. Terms and Conditions of the State's RFP.

The RFP for Contractual Services form must be signed using an indelible method (not electronically) and returned per the schedule of events in order to be considered for an award.

Noted.

Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

Noted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

Noted.

Further, Sections II through VII must be completed and returned with the proposal response.

Noted.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

UnitedHealth Group has its registered and principal executive offices at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343. UnitedHealth Group's telephone number is (952) 936-1300 or (800) 328-5979, and the fax number is (952) 936-7430. The website address is www.unitedhealthgroup.com.

UnitedHealth Group, a Delaware corporation originally organized in Minnesota in January 1977 and reincorporated in Delaware on July 1, 2015, is the ultimate controlling entity in the insurance holding company system. It was formerly named United HealthCare Corporation.

UnitedHealthcare Insurance Company, the legal entity with which we quote our fully insured business, is a C-Corporation.

UnitedHealthcare Insurance Company is located at 185 Asylum Street, Hartford, Connecticut 06103-0450.

b. **FINANCIAL STATEMENTS**

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

Please refer to the 2017 UHIC Audited Financial Statements, included in Section 12.

James F. Bedard
185 Asylum Street, Hartford Connecticut 06103
(860) 702-6811
james_f_bedard@uhc.com

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

Not applicable, as we are a publically-held corporation.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

As a result of the nature of our industry, we are periodically the subject of routine, random and other investigations and audits that relate to our contracts with public bodies. Some of these reviews are ongoing, and the outcome cannot be predicted. None of these matters would in any way impede our ability to meet our obligations under our contract.

We can share some general comments about our litigation history; however, for confidentiality reasons, we are unwilling to disclose detailed information.

In providing health benefit services and claims administration services, we have been involved in litigation. The majority of suits are brought by those seeking to challenge benefit decisions or to allege liability for malfeasance of some nature.

Our law department conducts an initial assessment of each suit filed against us and recommends whether the matter should be resolved or referred to local counsel for defense. Many of the suits against the company are resolved by settlement or by dispositive motions. None has had a known, material impact on our businesses or practices.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

Noted.

c. **CHANGE OF OWNERSHIP**

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

There are no pending or anticipated ownership changes. As a public company, our shares trade every day, but the large owners have generally been stable and no one has (or is expected to) purchase a 10 percent or greater position in the company.

d. **OFFICE LOCATION**

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

All claims are processed at our South Portland, Maine office. Our call center is also located in South Portland, Maine.

The person with overall responsibility for your account is your strategic client executive, Jane Perez.

All correspondence should be sent to Post Office Box 7466, Portland, Maine 04112-7466.

The physical address is 300 Southborough Drive, South Portland, Maine 04106.

e. **RELATIONSHIPS WITH THE STATE**

The bidder should describe any dealings with the State over the previous three (3) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

In the previous 3 years, UnitedHealthcare has the following contracts with the State of Nebraska

51597 04 Effective 7/1/12 to 6/30/18 – State Employee Medical and Pharmacy Administration

77103 04 Effective 7/1/18 to 6/30/20- State Employee Medical and Pharmacy Administration

64226 04 Effective 7/1/15 to 12/31/16 – Medicaid

71163 04 Effective 1/1/17 to 12/31/21 – Medicaid

f. **BIDDER'S EMPLOYEE RELATIONS TO STATE**

If any Party named in the bidder's proposal response is or was an employee of the State within the past twenty four (24) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

To the best of our knowledge, we are not aware of any lobbying that has occurred in connection with this procurement, nor are we aware of any gifts or other items of value have been provided to the State officials or employees.

g. **CONTRACT PERFORMANCE**

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.

If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

We are not aware of any cases where we were awarded work and did not complete it.

Contractual arrangements with our customers are confidential during the agreement period, as well as following termination.

h. **SUMMARY OF BIDDER'S CORPORATE EXPERIENCE**

Contractor should have a minimum of seven (7) years of STD insurance and claims administration experience and a minimum of seven (7) years of LTD insurance and claims administration experience.

Confirmed.

The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

This response has been redacted from the proposal. The State of Nebraska Subcontractor List can be found in the separately packaged envelope marked "Proprietary Information."

ii. Contractor and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as Subcontractor projects.
Noted.

iii. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, Subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.
UnitedHealth Group provides most of our core health care delivery services through our proprietary capabilities within our family of companies. This enables us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

UnitedHealth Group directly maintains trusted relationships with a variety of external sourcing partners managed through required Master Service and Business Associate Agreements in addition to a disciplined and focused approach on contract compliance, performance management and information security.

UnitedHealth Group's trusted relationships with our sourcing partners are managed within a shared service structure supporting a variety of customers, products and markets and are not typically dedicated to a specific customer. Those sourcing partners who may touch your account would be identified based on your benefit plan structure, our internal business processes and your expectations.

i. **SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH**
The bidder should present a detailed description of its proposed approach to the management of the project.

You will be supported by a multi-functional account management team who will be well-trained in your benefit program and cultural requirements. The account management team, led by the strategic client executive, Jane Perez, contains representation from all disciplines specifically required to serve your needs.

The account management team assigned to your account delivers on our promise to maximize the investment that you make in health care. The team's top priority is building a successful partnership with you to address your overall goals and coordinate day-to-day activities. The team is your point of contact for all aspects of administration, claims, underwriting, contracts, eligibility, billing and reporting, and works to ensure that all of your needs are met.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

Please refer to the State of Nebraska – Management and Service Team, included in Section 12, which includes the requested information. Please note members of the account management team report to varied department managers – including client services, operations, implementation, financial, computer system, etc. – based on their individual role.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.

Please see the Jane Perez Resume, Jelena Edwards Resume, Clifton Sumrall Resume, Ann Marie Strought Resume, Kim Blais Resume, and Travis Jordan Resume, each of which are included in Section 12.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Noted.

j. **SUBCONTRACTORS**

If the bidder intends to Subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the Subcontractor(s);
ii. specific tasks for each Subcontractor(s);
iii. percentage of performance hours intended for each Subcontract; and
iv. total percentage of Subcontractor(s) performance hours.

Please refer to the Subcontractor Listing for State of Nebraska, included in Section 12.

UnitedHealth Group and its affiliates manage their respective Shared Service Operations comprised of comprehensive processes and systems which support our customers across various markets and product platforms. Likewise, UnitedHealth Group closely manages various trusted 3rd party suppliers for their unique healthcare service delivery capabilities to support specific areas of our internal operations. As such, these Shared Service Operations are intended to leverage breadth and depth in our capabilities to ensure we excel on our customer commitments (i.e. cost, quality and performance, etc.) in health care delivery and health plan management.

3. **TECHNICAL APPROACH**

The technical approach section of the Technical Proposal should consist of the following subsections:

a. Understanding of the project requirements;
b. Proposed development approach;
c. Technical considerations;
d. Detailed project work plan; and
e. Deliverables and due dates.

Throughout the implementation process, our goal is to build a successful partnership with you. Implementation begins with your Client Manager, Jelena Edwards, who is responsible for facilitating the implementation of your account, by working closely with our internal Implementation Manager.

Jelena schedules an implementation meeting to expedite a smooth benefit plan transition. At this meeting, the following is discussed:

- **Roles and Responsibilities: Review of key contacts and accountabilities for implementation**
- **Implementation Timeline: Review of the key milestones and deadlines for case installation, including meeting schedules**
- **Products and Services: Detailed discussion of what we will provide, including a complete description of the benefit plan(s)**
- **Eligibility and Reporting: Description of eligibility and financial reporting needs**
- **Enrollment Strategy and Communication Materials: Enrollment meeting strategy and resources, including member materials like enrollment forms and benefit summaries**

After the initial meeting, Jelena completes the detailed steps of the implementation, working with experts from claims, customer service, eligibility, contracts, billing, reporting and underwriting.

Jelena is in frequent contact with you throughout the implementation process to ensure that the following activities occur accurately and on time:

- **Benefit Design: We load the benefit design information into the appropriate systems in advance of the effective date. Claim and customer service systems are fully tested.**
- **Billing: Our billing systems are set up to process monthly payments and maintain records so we can produce a variety of financial reports.**
- **Claims: Claims systems are set up to accurately pay claims.**
- **Customer Service: The call center can answer questions about coverage during the open enrollment period and beyond.**
- **Contract Administration: Contracts are drafted and submitted to you for review and final approval.**
- **Communication Materials: We will produce enrollment materials, such as enrollment/change forms and beneficiary forms.**

Please refer to the Sample Implementation Timeline, included in the Section 12 of the RFP, for a detailed breakdown of tasks, suggested timeline, and responsible parties.

Form A Bidder
Contact Sheet
Request for Proposal Number 5956 Z1

Form A should be completed and submitted with each response to this RFP. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	UnitedHealthcare Insurance Company
Bidder Address:	185 Asylum Street Hartford, CT 06103
Contact Person & Title:	Jane Perez, Strategic Client Executive
E-mail Address:	jane_l_perez@uhc.com
Telephone Number (Office):	(763) 283-3597
Telephone Number (Cellular):	(402) 312-3282
Fax Number:	(866) 745-1551

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	UnitedHealthcare Insurance Company
Bidder Address:	185 Asylum Street Hartford, CT 06103
Contact Person & Title:	Jane Perez, Strategic Client Executive
E-mail Address:	jane_l_perez@uhc.com
Telephone Number (Office):	(763) 283-3597
Telephone Number (Cellular):	(402) 312-3282
Fax Number:	(866) 745-1551

A

ADDENDUM TWO,
QUESTIONS and ANSWERS

Date: November 29, 2018

To: All Bidders

From: Teresa Fleming, Buyer
AS Materiel State Purchasing

RE: Addendum for Request for Proposal Number 5956 Z1 to be opened December 13, 2018 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

<table>
<tr><th>Question Number</th><th>RFP Section Reference</th><th>RFP Page Number</th><th>Question</th><th>State Response</th></tr>
<tr><td>1.</td><td></td><td></td><td>Can we please have a census that is all eligible for the STD/LTD, Occupation, and Zip code?</td><td>Refer to Attachment G – Eligibility Census.</td></tr>
<tr><td>2.</td><td></td><td></td><td>Please have the occupations added to the LTD enrolled census.</td><td>Refer to REVISED Attachment F Census Report.</td></tr>
<tr><td>3.</td><td></td><td></td><td>The RFP reflects that there are 15,670 full time and temporary employees eligible for the STD and LTD coverages. Please provide a complete census for all of these employees.

* Please also include a column to identify the full time verses temporary employees.</td><td>Refer to Attachment G – Eligibility Census.</td></tr>
<tr><td>4.</td><td></td><td></td><td>Please provide a copy of the Mutual of Omaha VLTD plans</td><td>Here is the most recent version of the Certificate of Coverage</td></tr>
<tr><td>5.</td><td></td><td></td><td>Please provide a key code for the “Class” codes on the LTD Open and Closed Claim Listing.</td><td><table><tr><th>Class Code</th><th>Definition</th></tr><tr><td>AX01</td><td>2 Month Elimination</td></tr><tr><td>AX02</td><td>3 Month Elimination</td></tr><tr><td>AX03</td><td>6 Month Elimination</td></tr><tr><td>AX04</td><td>9 Month Elimination</td></tr></table></td></tr>
<tr><td>6.</td><td></td><td></td><td>If the “Class” on the Open and Closed Claim Listing does not identify which plan the claimants are enrolled in, please have the claims listings updated to reflect that information.</td><td>Refer to the response in Question 5.</td></tr>
<tr><td>7.</td><td></td><td></td><td>Please provide any previous VLTD rates (rate history) and when those rates were in place (from – to)</td><td>Rates have not changed since 2013.</td></tr>
</table>

8.			Have there been any plan changes to the VLTD? If yes, please outline what provisions were changed, the date of the change and provide the previous plan provision. For example, the maximum was increased from 5,000 to 7,500 effective 1/1/2016.	No. N/A
9.			Do the State of Nebraska employees participate in social security?	Yes.
10.			Do the State of Nebraska employees participate in the Public Employees Retirement System.	Yes.
11.			Do the State of Nebraska employees participate in the State Teacher Retirement System?	Yes.
12.			Please provide a Paid and Incurred Exhibit for the VLTD from Mutual of Omaha.	Refer to Attachment H – Paid Claims and Triangle
13.			Please provide the Offset Amounts for each of the VLTD Open Claims.	Refer to Attachments I, J, K and L (Payment Detail for Classes 1, 2, 3 and 4)
14.			Please provide the paid sick leave and/or salary continuation paid during 2017 for STD.	The State has not had a short term disability plan.
15.			Please provide the paid sick leave and/or salary continuation paid during 2018 for STD.	The State has not had a short term disability plan.
16.			Please provide a census with the following information: o All eligible employees. Currently the census only has those participating. They are asking us to change the plan design and add STD as first-time coverage, so we need the entire eligible population for rating purposes.	The State has not had a short term disability plan. Refer to Attachment G – Eligibility Census.

			o Job descriptions. The State of Nebraska has different pension plans depending on the nature of employment. We need job descriptions to determine the proper pension plan offsets, as well as to get a clear picture of our exposure in the voluntary plan.	
17.			Please provide an LTD certificate to determine the exact provisions of the inforce plan.	Refer to the response in Question 4.
18.			Please provide a detailed claim listing with offsets and classes o This is a four-tier voluntary inforce plan with differing elimination periods and a state pension.	Refer to the response in Question 13.
19.			Does the group have any sort of ASO/Salary Continuation plan in place today as a placeholder for STD? If yes, can we get information on the plan?	No.
20.			Is the group eligible and participating in Social Security? It appears there is state-mandated plan.	Yes.

21.			Please confirm the State is looking to completely move off of their current four-tier VLTD and move forward with ONLY the 180 day EP. o If confirmed, would there be a mass re-enrollment for the whole group? What will happen to the current enrollees that are not on the 180 day EP? Will they be shifted to this EP, or will they be dis-enrolled and have to re-enroll?	Yes. Yes, with EOI approval. All current (with any elimination period) will have to re-enroll with no EOI approval. Re-enroll.
22.			The State is requesting no pre-ex on both VLTD and VSTD. Is this a deal-breaker? This is highly risky for voluntary plans.	The State is requiring no pre-existing on LTD for currently enrolled employees. New enrollees on LTD and all enrollees on STD are subject to pre-existing limitations.
23.			Are there any union members in the group currently? If so, we would need them broken out on the census as well.	Refer to Attachment G – Eligibility Census.
24.			It appears that we did not receive the paid LTD claims on an incurred basis. Attachment E has premium and claims on a monthly cash flow basis, not incurred. Please provide paid claims, paid premium and reserves for the last 5 years.	Refer to Attachment H – Paid Claims and Triangle
25.			Detail any rate or plan changes since 2013.	None.
26.			Please provide a current premium statement.	Refer to Attachment O Invoice.
27.			Please provide the current Long Term Disability certificate.	Refer to the response in Question 4.

28.	"		Are State of Nebraska employees eligible for any Public Employee Retirement Systems (PERS) benefits? Does the group participate in SSDI?	Yes. Yes.
29.	V. Project Description and Scope of Work A. Project Overview	32	Per the RFP, the Disability plans will cover temporary employees. How many temporary employees are eligible? Are these employees on a temporary assignment? How long is the average work period for temporary employees?	Refer to Attachment G – Eligibility Census. Temporary employees with an assignment of 6 months or longer they are eligible. The State does not have the average work period for temporary employees.
30.	Census		Please provide a complete eligible census including enrollment indicator with plan selection for the current Voluntary Long Term Disability plan. The census should include gender, date of birth, occupation and salary/earnings.	Refer to Attachment G – Eligibility Census.
31.	Cost Proposal		Please confirm the Voluntary Short Term Disability rate basis should be per $100 monthly covered payroll instead of per $10 weekly benefit.	STD should be priced on a "per $10 of weekly benefit" basis; LTD should be priced on a "per $100 of covered monthly payroll" basis. Refer to REVISED Cost Proposal.
32.	Attachments C &D		Please provide a Class Key for the Attachments C &D (AX01, AX02, etc.) Which LTD plans do these codes represent?	Refer to the response in Question 5.
33.	V. Project Description and Scope of Work C. Administration Requirements	25	Regarding: Coordinates with State's online enrollment vendor. Please advise what will be expected of insurance carrier.	Enrollment is on-line in the State's system and EOI is on paper which is submitted to the State and forwarded to the Contractor for processing.
34.	Attachment A Contractor	1	Regarding 3. There will be no restrictions or benefit	Refer to the response in Question 22.

	Requirements Matrix		limitations for pre-existing conditions applied to any employee under the plan. Please elaborate on the intent of this requirement; Voluntary Long Term Disability and Voluntary Short Term Disability plans typically include a pre-existing condition exclusion.	
35.	Attachment A Contractor Requirements Matrix	3	Regarding: 23. When customized printing is requested by the State, present a complete draft and subsequent proof to the State for sign-off. The Contractor must ensure that logo placement and color requirements are met. Contractor will be responsible for costs of printing booklets, certificates, or SPDs as required. Please advise approximate number of copies, and if the mailing should be to the State for distribution or to employee homes.	Flyers or informational materials to provide during Open Enrollment process. The quantity would be approximately 600 pieces. The certificate booklet or other items can be sent electronically to the State to post on the website. The distribution will not be sent to employee's homes.
36.	I. Procurement Procedure i. Submission of Proposals	3	Please confirm that only one (1) original hard copy binder is requested?	Confirmed.
37.	I. Procurement Procedure i. Submission of Proposals	3	Regarding the "Technical" and "Cost" sections of the response, please confirm that we can put both within the 1 requested binder but separated into separate sections?	Confirmed.
38.	Census		Please provide a census of all eligible employees for VSTD.	Refer to Attachment G – Eligibility Census.
39.	Census		Can the all eligible census show the amount of sick leave an employee has?	Refer to Attachment G – Eligibility Census.

40.	Census		Please provide a LTD census that shows occupations for the employees.	Refer to Attachment G – Eligibility Census.
41.	Contracts		Please provide the actual VLTD cert. What we have now is a benefits summary. We know that they are sliding to a 180 day ep plan but we want to make sure the benefits and provisions align well behind the ep.	Refer to the response in Question 4.
42.	V. Project Description and Scope of Work B. Current and Future Environment	24	How do they intend the STD and sick leave to integrate? They are not to be forced to exhaust sick leave before using STD; therefore, do they want a 100% integration layering effect?	The State requires that the short term disability run concurrently with the employees using at least 5 sick days (40 hours), so the duration starts on day one.
43.	V. Project Description and Scope of Work B. Current and Future Environment	24	What amount of sick leave will they accrue going forward?	There is no change in sick leave accrual at this time.
44.	V. Project Description and Scope of Work B. Current and Future Environment	24	Can the State define temporary employee, as they ask bidders to cover them?	Per the State of Nebraska Options Guide: "Temporary Employees: Eligible for the state's group health, dental, long-term disability, HSA, and FSA dependent care plans if they work at least 20 hours per week and are placed in a position with a six-month assignment or longer."
45.	VII. Cost Proposal Requirements A. Cost Sheet	30	Please confirm if you want STD billed as per 100 monthly covered payroll?	Refer to the response in Question 31.
46.	Experience		Please provide information and data on the STD utilization, including basic duration and incidence data.	The State has not had a short term disability plan.
47.	Experience		Do the class markers on the LTD claims reports correspond to the VLTD	Refer to the response in Question 5.

			enrollment options? If so, what is the 'key'?	
48.	Experience		Please provide the premium vs claims on an incurred basis.	Refer to Attachment H – Paid Claims and Triangle
49.	Experience		Please provide an open claims listing with 'total paid'.	Refer to Attachments I, J, K and L (Payment Detail for Classes 1,2,3 and 4)
50.	Experience		Does the open claims listing list gross or net benefit?	No. Refer to Attachments I, J, K and L (Payment Detail for Classes 1,2,3 and 4)
51.	Experience		Can we receive diagnosis, offset status or salary for the LTD open claims?	Diagnosis not available. Refer to Attachments I, J, K and L (Payment Detail for Classes 1,2,3 and 4)
52.	General		What are the State's intentions regarding enrollment?	Refer to the response in Question 33.
53.	General		Who would handle the enrollment? Are they enrolling online? What is the roll out like?	Refer to the response in Question 33.
54.	General		While this is a separate bid, what is the State's opinion of [redacted] service on the Life side?	The State will not answer this question as it is not relevant to the RFP.
55.	General		Did this RFP go out to all carriers since this is a direct bid?	This is a public Request for Proposal.
56.	General		How does the State feel about their inforce carrier, [redacted]?	The State will not answer this question as it is not relevant to the RFP.
57.	General		Do employees participate in Nebraska PERS or Social Security or both?	Yes, both.
58.	N/A	N/A	Please provide a copy of the current LTD contract.	The current Contract is 55674 O4.
59.	N/A	N/A	Who is the current administrator for your FML?	It is self-administered by the State.
60.	V. Project Description, Sub C Administration requirements, question #7	33	Who is the online enrollment vendor and explain "Coordinates with State's online enrollment vendor".	Refer to the response in Question 33.
61.	V. Project Description, Sub B Current and Future environment	32	What is the min and max for the current LTD and new STD plan?	Current LTD is: $100 minimum and $7500 monthly maximum The STD Plan will be:

				$25/week and maximum of $1,731/week.
62.	V. Project Description & Scope of Work (B.)	Pg. 24	Can an updated LTD Open Claims report (Attachment D) with net benefit and total paid amounts be provided?	Refer to Attachments I, J, K and L (Payment Detail for Classes 1,2,3 and 4)
63.	V. Project Description & Scope of Work (B.)	Pg. 24	Can The State confirm that Class code on the claim reports (Attachment C and D) corresponds to the Elected Elimination Period option (i.e. AX01 = EE elected LTD EP option 1 60 days)?	Refer to the response in Question 5.
64.	V. Project Description & Scope of Work (B.)	Pg. 24	Can a report with historical LTD premium by Elimination Period be provided?	Refer to Attachment N – Historical LTD Premium Payments
65.	V. Project Description & Scope of Work (B.)	Pg. 24	Can a copy of the current LTD certificate of coverage be provided?	Refer to the response in Question 4.
66.	V. Project Description & Scope of Work (B.)	Pg. 24	Can historical LTD rate history be provided back to 2013?	Refer to the response in Question 7.
67.	V. Project Description & Scope of Work (B.)	Pg. 24	Can a revised LTD census with each employee's occupation or job title be provided?	Refer to the response in Question 2.
68.	V. Project Description & Scope of Work (B.)	Pg. 24	Are there any Labor or Union negotiated benefits that will impact or change the LTD plan design during the rate guarantee period?	There is currently no bargaining that would impact the LTD Plan.
69.	V. Project Description & Scope of Work (B.)	Pg. 24	Have there been any LTD plan design changes since inception (2013) with Mutual of Omaha?	Refer to the response in Question 25.
70.	V. Project Description & Scope of Work (B.)	Pg. 24	Can a copy of the Employee sick leave bank be provided?	Refer to Attachment G – Eligibility Census.
71.	V. Project Description & Scope of Work (B.)	Pg. 24	Do State employees participate in both Social Security and a Public Employee Retirement System?	Yes, both.
72.	V. Project	Pg. 24	How many SOS	Refer to Attachment G –

	Description & Scope of Work (B.)		Temporary Employees are benefit eligible? Can a revised census be submitted that identifies those employees?	Eligibility Census.
73.	Attachment B Current Long-Term Disability Benefits	1	Have the current LTD rates been in effect since 7/1/2013? If not, please provide rate change history.	Refer to the response in Question 25.
74.	Attachment B Current Long-Term Disability Benefits	1	Have there been any LTD plan changes since 7/1/2013? If so, please describe.	Refer to the response in Question 25.
75.	Attachments C & D Claim Listings	All	Do State of Nebraska employees contribute to Social Security, PERS or both?	Yes, both.
76.	Attachment C Closed Claim Listing for Group	All	Please provide code descriptions for the 'Class' column.	Refer to the response in Question 5.
77.	Attachment D Open Claims Report	All	Are the values in the 'Benefit Amount' column the gross benefit, net benefit or something else?	The values are Net Benefit.
78.	Attachment D Open Claims Report	All	Please provide gross benefit, offset amounts, offset sources and net benefit for all open claims.	Refer to Attachments I, J, K and L (Payment Detail for Classes 1,2,3 and 4)
79.	Attachments C & D Claim Listings	All	Please provide a 'Paid & Incurred' exhibit with a Valuation Date of 7/31/2018 for the time period 7/1/13 through 6/30/18. The exhibit should have 12-month periods with claim payments allocated to the period that corresponds with the claimant's date of disability. The exhibit should also contain open claim reserves and interest credits that also correspond to the period in which disability was incurred. Please provide a separate exhibit for	Refer to Attachment D – Open Claims, Attachment H – Paid Claims and Triangle and Attachments I, J, K and L (Payment Detail for Classes 1, 2, 3 and 4)

			each of the four elimination periods if possible. Otherwise, please provide one complete exhibit which reflects all elimination period options.	
80.	RFP Final	24	Please provide sick leave balances for each employee enrolled in LTD. Otherwise, please provide average sick leave balance for the group and a description of how sick leave is accumulated.	Refer to Attachment G – Eligibility Census.
81.	RFP Final	24	For the July 2019 enrollment into the new LTD plan, will all current employees enrolled in LTD be defaulted into the new plan or will everyone (including current participants) need to actively enroll in coverage?	Refer to the response in Question 33.
82.	RFP Final	24	For the July 2019 enrollment into the new STD plan, will current LTD participants be automatically enrolled in the STD or will everyone (including current participants) need to actively enroll in coverage?	All employees will need to actively enroll in desired coverage.
83.	RFP Final C. Administration Requirements (2G)	25	Please provide more detail around the requirement that the STD and LTD contractor "responds to participant questions on enrollment and benefits."	Contractor must be able to answer questions about the plan if directly outreached by a participant.
84.	RFP Final C. Administration Requirements (3A)	25	Please provide more detail around the requirement that the STD and LTD contractor "approves all communication materials prior to distribution."	The State approves all communication materials prior to distribution not the Contractor.
85.	RFP Final C. Administration	25	Please provide more detail around the	Bidder should respond to meet the requirements of

	Requirements (4E)		requirement that the STD and LTD contractor "remits the State's portion of Medicare tax (from a State Medicare matching Fund) to the federal government."	the RFP.
86.	RFP Final C. Administration Requirements (6A)	25	Please provide more detail around the requirement that the STD and LTD contractor "coordinates with other programs that provide Deductible Income (offset income) when applicable."	The Contractor will be responsible for coordinating with the member and/or State of Nebraska regarding offset income. This will help to eliminate overpayments.
87.	RFP Final C. Administration Requirements (7A)	26	Please provide more detail around the requirement that the STD and LTD contractor "coordinate with State's online enrollment vendor."	Refer to the response in Question 33.
88.	RFP	24	Does the State want to offer a maximum benefit for the VSTD coverage that is similar to the VLTD maximum benefit?	Refer to the response in Question 61.
89.	Attachment F		Please add the eligible employees who waived VLTD coverage to the census.	Refer to Attachment G – Eligibility Census.
90.	Attachment F		Please add a column for occupations to the census for all eligible employees.	Refer to Attachment G – Eligibility Census.
91.	Attachment F		Please add a zip code column to the census for all eligible employees.	Refer to Attachment G – Eligibility Census.
92.	Attachment F		Can we please have a census that is all eligible for the STD/LTD, Occupation, and Zip code?	Refer to Attachment G – Eligibility Census.
93.	V-B	24	Does the LTD & STD plan include a pre-existing condition exclusion?	Refer to the response in Question 22.
94.	V-B	24	Who is the current carrier for the State's LTD plan?	Mutual of Omaha.
95.	V-B	24	Does the State prefer to have both LTD and STD plans with the same carrier?	LTD and STD plans must be by the same carrier.
96.	V-B	24	What is the current	Refer to Attachment G –

			participation on the LTD plan? The census indicates that it includes information for all eligible, but it doesn't indicate current enrollees.	Eligibility Census.
97.	Attachment A		Can the State clarify what it means by 'fraud monitoring and detection'?	Contractor must follow-up on monitoring on disabled participants, if necessary.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

Deviations to the plan designs

We have provided a quote based on the RFP specifications: 100% employee pay LTD with 1 EP option of 180 days with 60% income replacement to a maximum $7500. The maximum benefit duration of SSNRA. Please refer to our proposal document. Standard UHC provisional language applies for all provisions not noted in the RFP specifications due to issuing a proposal based on a plan design change.

Deviations to the in-force contract

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES:

["All documentation produced or created exclusively for the City under such a Contract, and not applicable to UnitedHealthcare's general book of business, shall be considered the property of the City. UnitedHealthcare claim payment methodologies and software, the software for our portals, processes related to appeals, our reimbursement policy and methodologies, UnitedHealthcare policies and technologies that identify when a policy should be applied simply cannot become "Work for Hire" items belonging to the State."]

JJ. PROPRIETARY INFORMATION

(Replace what is in the in-force contract with the language below)

Data contained in the contract and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information. IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. §84-602.02, all State contracts in effect as of January 1, 2014 will be posted to a public website beginning July 1, 2014. All information not specifically excluded by State Law WILL BE POSTED FOR PUBLIC VIEWING.

B

This information is considered trade secret, proprietary and/or competitively-sensitive confidential information. Disclosure of the information would cause substantial harm to UnitedHealthcare, is information that UnitedHealthcare would not customarily release to the public and is known only to certain individuals with a need to know. It should not be released by State of Nebraska without the prior written consent of UnitedHealthcare.

- **Section 9 - References**
- **Section 12F - Resumes**
  - Jane Perez
  - Ann-Marie Strought
  - Clifton Sumrall
  - Jelena Edwards
  - Kim Blais
  - Travis Jordan
- **Section 12K – Subcontractor Listing**

C

Our parent company, UnitedHealth Group Incorporated, has been operational in the life and accidental death and dismemberment market since 1990. UnitedHealth Group currently employs more than 270,000 people across all its businesses.

UnitedHealth Group, Incorporated (UnitedHealth Group) is a diversified health and well-being company dedicated to making health care work better. Headquartered in Minneapolis, Minnesota, UnitedHealth Group uses two business platforms, UnitedHealthcare and Optum, to offer a broad spectrum of products and services.

UnitedHealthcare coordinates network-based health and well-being products and services that are innovative and affordable and that keep individuals involved in their own health and wellness. After all, informed consumers make better decisions, and that leads to lower medical costs. In addition to health benefit plans, UnitedHealthcare offers Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs), as well as specialty programs such as vision, dental, life, disability, accident and critical illness protection and hospital indemnity protection.

We have more than 20 years of experience serving more than 1 million financial protection members and 43,000 employer groups.* Our financial protection plans help offer an easier, economical way to enhance your benefits package, help your employees to live healthier and help your business be more productive. Our competitive financial protection portfolio includes the following plan offerings. Not all plans are available in all states:

- Life (basic and supplemental) & accidental death and dismemberment
- Disability (short and long-term) & family medical leave administration
- Critical illness protection
- Accident protection
- Hospital indemnity protection

Fund them your way.
Our flexible funding options let you choose the right plans and contribution strategies (non-contributory or voluntary) for your needs and budget.

Protect employee productivity.
Our financial protection plans help ease budget strain for you and your employees. They also help lower emotional stress so employees can focus on getting better, not how to pay their bills.

Bundle with our health plans for even more value.
It's easy to add a financial protection plan and get these advantages at no extra cost.

- **See savings**. You may qualify for significant savings by bundling your plans. Bundle more, save more. You may also save time with more efficiency.
- **Enjoy simplicity**. Get one account team, administration process and website, customer service line and more.
- **Inspire healthier**. Bridge2Health® uses our health plan and specialty plan data to identify and empower your employees with support and resources that can help them make informed decisions and take control of their health. Though better integration, we can help influence better health outcomes, help improve productivity, help reduce absenteeism and help lower costs.

*Data as of January 2017.

D

Benefit Administration

Financial protection

Benefit plan implementation process

At UnitedHealthcare, we are committed to partnering with you in the implementation and administration of your benefit plan. We will work closely with you to ensure a smooth transition and successful business relationship.

The chart below identifies key steps in the process of implementing your policy along with their estimated time frames. We look forward to serving you.

Timing	Implementation steps	Implementation responsibility		
1 - 2 Weeks	**Pre-installation: Information gathering**	**UnitedHealthcare**	**Joint effort**	**Your company**
	1. Your UnitedHealthcare sales team provides final sold proposal to the Financial Protection Support team (FPS)	●		
	2. FPS team will prepare your customized implementation packet	●		
	3. FPS team will email implementation packet with a request to schedule an implementation meeting	●		
	4. Hold initial implementation conference call/meeting to review implementation packet, plan design and administration requirements		●	
	5. Resolve any outstanding items from implementation meeting			●
	6. Obtain client and producer approval of final plan design			●
	7. Provide written notice to prior carrier as necessary			●
1 - 10 Business days	**Installation: Begins upon completion of all installation forms**	**UnitedHealthcare**	**Joint effort**	**Your company**
	1. Distribute customized enrollment form and benefit summaries as agreed upon	●		
	2. Final census must be provided at this time to continue installation			●
	3. Benefit plan will proceed to case set up upon receipt	●		
	4. UnitedHealthcare conducts internal operations case review for fast-track installation	●		
	5. Case installation reviewed by the underwriting team.	●		
10 - 20 Business days	**Policy administration: Begins upon approval from underwriting**	**UnitedHealthcare**	**Joint effort**	**Your company**
	1. Issue policy and certificate of coverage and forward to account executive/manager, broker and client	●		
	2. Review electronic forms notice and confirm receipt via email			●
	3. Client will receive welcome email with Web-ID and password	●		
20 - 30 Business days	**eAdminstration training**	**UnitedHealthcare Specialty Benefits**	**Joint effort**	**Your company**
	1. Account executive will request administration training call with client, broker and FPS team to discuss the following: • Web access • Billing process • Reporting system • Ongoing service contacts		●	

This checklist reflects typical steps in benefit implementation and administration. Actual steps will be determined on a case-by-case basis, based on the specific needs of the customer.

UnitedHealthcare®

MT-986388.0 11/15 15-0269-B

Corporate officer who has decision-making authority for this account
Name: Mark Olson
Location: Denver, CO
Title: Vice President of Sales and Account Management
Responsibilities: Mark has overall sales and account management responsibility for the Colorado health plan.
Experience: Mark has been vice president for the Colorado health plan the past 4 years and been in the industry for 20 years. He previously was vice president of Sales and Account Management for our Arizona health plan.

Corporate officer assigned responsibility for implementation
Name: Vivian Lindsay
Location: Ft Lauderdale, FL
Title: Sr. Vice President, Operations
Responsibilities: Vivian has overall responsibility for implementation of Financial Protection products at UnitedHealthcare.
Experience: Vivian has been with UnitedHealthcare since 2005.

Account Executive
Name: Jennifer Behm
Location: Denver, CO
Title: Account Vice President, Key Accounts
Responsibilities: Jennifer is responsible for the management of strategic relationships and oversight for assigned Public Sector and Key Accounts for UnitedHealthcare.
Experience: Jennifer brings extensive, focused experience in client management to her role at UnitedHealthcare. She has held positions of increasing responsibility at UHC since being hired in July of 2010, including Account Manager, Senior Account Manager and her current title, Account Vice President. Jennifer has a passion for service excellence and the contribution that strong and focused account management brings to UHC customers.

Claim manager for Life/AD&D claims
Name: Vicky Locke
Location: South Portland, ME
Title: Manager, Life, AD&D and Life Waiver of Premium Claims
Responsibilities: Vicky is responsible for the oversight of the claim specialists, explaining policy provisions, process, timeframes and exceptions and complex claim resolution.
Experience: Vicky has more than 30 years of insurance experience, employed with UnitedHealthcare for 9.5 years, has managed current team of life specialists and life waiver of premium specialists for the past 6 years and prior to her manager role she was team lead for life waiver of premium.

Claim manager for Waiver of Premium claims
Name: Vicky Locke
Location: South Portland, ME
Title: Manager, Life, AD&D and Life Waiver of Premium Claims
Responsibilities: Vicky is responsible for the oversight of the claim specialists, explaining policy provisions, process, timeframes and exceptions and complex claim resolution.
Experience: Vicky has more than 30 years of insurance experience, employed with UnitedHealthcare for 9.5 years, has managed current team of life specialists and life waiver of premium specialists for the past 6 years and prior to her manager role she was team lead for life waiver of premium.

Underwriting manager for group rates
Name: Chris Chambers
Location: Hartford, CT
Title: Vice President, Financial Protection Underwriting
Responsibilities: Chris is responsible for underwriting for all Financial Protection products which includes Life, Disability and Supplemental Health products. He is also responsible for the Evidence of Insurability team.
Experience: Chris has 31 years in underwriting with progressively increasing responsibility spanning medical, dental, vision, pharmacy and financial protection lines. Chris has handled all client size levels from as little as 2 and as many as several hundred thousand. Chris' career includes experience with multiple high quality national carriers.

Underwriting manager for approving evidence of insurability
Name: Chris Chambers
Location: Hartford, CT
Title: Vice President, Financial Protection Underwriting
Responsibilities: Chris is responsible for underwriting for all Financial Protection products which includes Life, Disability and Supplemental Health products. He is also responsible for the Evidence of Insurability team.
Experience: Chris has 31 years in underwriting with progressively increasing responsibility spanning medical, dental, vision, pharmacy and financial protection lines. Chris has handled all client size levels from as little as 2 and as many as several hundred thousand. Chris' career includes experience with multiple high quality national carriers.

Portability / Conversion manager
Name: Lorrie Burckhard
Location: Minnetonka, MN
Title: Billing Manager (Financial Protection Products)
Responsibilities: Lorrie manages billing and accounts receivables for life, disability, supplemental health and portability products.
Experience: Lorrie has 20 years' experience with UnitedHealthcare.

1998–2006: Managed the Stop-Loss Accounts Receivable Premium department

2007–Present: Manage the Association Business Life and DI Billing/AR department

2016–Present: Manage the Employer Group Life, Disability, Supplemental Health and Portability Billing/AR Department

IT manager
Name: We will be happy to provide IT Manager name upon finalist notification.
Location: We will be happy to provide IT Manager location upon finalist notification.
Title: We will be happy to provide IT Manager title upon finalist notification.
Responsibilities: We will be happy to provide IT Manager responsibilities upon finalist notification.
Experience: We will be happy to provide IT Manager experience upon finalist notification.

Report manager
Name: Teresa Niu
Location: Santa Ana, CA
Title: Director, Information Management and Reporting
Responsibilities: Teresa provides reporting solutions for Financial Protection products.
Experience: Teresa has 20+ years of working in business intelligence area in healthcare and leading a reporting team that delivers business intelligence solutions to clients.

Customer service manager
Name: Barbara Buenemann
Location: St Louis, MO
Title: Sr. Director, Broker & Employer Services for Public Sector
Responsibilities: Barbara has responsibility for operations support of Public Sector customers and the interfaces with claims, customer care and appeals functions within UnitedHealthcare.
Experience: Prior to this role, Barb led the National Appeals Service Centers, the consolidated health plan Customer Care centers and had been Chief Operating Officer for UnitedHealthcare of Midwest.

RFP/Sales contact person
Name: Craig Peters
Location: Denver, CO
Title: Senior Account Executive, Specialty Products
Responsibilities: Craig has sales responsibilities for all ancillary lines that UHC offers for Colorado and Wyoming in our Key Account segment (100+ employees).
Experience: Craig has been with UnitedHealthcare for 3.5 years and has been in the industry for 8 years. He has vast experience with Life insurance and has helped to drive massive growth in our Financial Protection business in Colorado.

ACCOUNT TEAM RESUMES

This section has been redacted from the proposal. The Account Team Resumes can be found in the separately packaged envelope marked "Proprietary Information."

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UNITEDHEALTH GROUP®

Enterprise Resiliency & Response Program Customer Overview

January 2018

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Section I – Enterprise Resiliency & Response Overview

Background

The purpose of this document is to demonstrate how the Enterprise Resiliency & Response Program, with the interrelated services of event management, site emergency planning, business continuity planning, disaster recovery planning, and response to events impacting public health and pandemics, are designed to ensure we can react quickly to all forms as disasters, minimizing potential negative impacts to our operations and vital services.

UnitedHealth Group has an Enterprise Resiliency & Response Program (the Program) that minimizes customer impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines.

The Program helps prevent and/or mitigate the impact of events that could disrupt our business by containing the impact within a predictable and predetermined period of time. Effective business continuity planning establishes the basis from which business processes and operations, including service to customers, are resumed.

We have business contingency planning preventative controls, contingency resources, and procedures administered by a formal internal management organization.

Mission Statement

The mission of the Program is to:

- Provide for the safety of our employees in the event of a business disruption or disaster
- Demonstrate our consumer-focus and service excellence when our customers and members are vulnerable after a crisis
- Minimize service disruptions
- Meet customer and other stakeholder expectations
- Preserve customer information
- Protect and preserve UnitedHealth Group's organizational assets, including people, process, technology and information
- Comply with laws and regulations regarding the continuity of operations
- Enhance our competitive position, market share and reputation

This mission can only be achieved through management and control of business impact and risk; therefore, the program focuses on designated critical operations and sites. The level of business continuity safeguards are based on the business impact of the business segment's critical operations, sites, assets, and their inherent vulnerabilities.

Policy

UnitedHealth Group recognizes and acknowledges that the protection of its assets and business operations is a major responsibility to its employees, shareholders, business associations, customers and other communities that it services. Therefore, it is UnitedHealth Group's policy that business continuity and disaster recovery plans must be developed, tested, and maintained in order to limit losses caused by disruptions to critical business operations and to enable efficient and effective recovery. The Program include processes and controls to protect the business of UnitedHealth Group, the life and safety of

workforce members, as well as to protect the image, reputation, assets, and resources of the organization.

Objective

The objectives of the Program are to continue to serve customers, minimize financial loss to the organization, and minimize the negative effects disruptions can have on strategic plans, reputation, operations, liquidity, credit quality, market position and ability to remain in compliance with applicable laws and regulations. Changing business processes, internally to the organization and externally among interdependent vendors and partners, and new threat scenarios require UnitedHealth Group to maintain updated and viable business continuity plans.

In order to carry out the Program mission, UnitedHealth Group has adopted a business continuity strategy to address the key business interruption risks that stem from the deployment and use of our people, processes, technology and financial assets in carrying out the day-to-day business operations. This strategy focuses on our critical business functions and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of our operations and assets. This worst-case scenario covers all forms of disasters, both natural and man-made (e.g., hurricane, flood, fire, terrorism, public health emergencies, including pandemics, etc.).

Program Strategy

The Program strategy requires that the ownership, responsibility and accountability for business continuity planning reside at the segment business operations level while providing for governance, standardization, and oversight at the enterprise level. This program encompasses a "layered" approach to continuity planning, which recognizes that risks to our business operations are inherent individually and to the environment as a whole due to the interdependent nature of our operations. Therefore, the continuity strategy is an appropriate combination of safeguards within our operations that work together to address inter-segment dependencies and meet the business continuity requirements of the segments individually, as well as UnitedHealth Group as a whole. Risk assessment, organizational accountabilities, governance and metrics are the foundational components of the Program and layered approach.

The Program integrates the appropriate levels of skills and required activities across all business operations. The level of business continuity safeguards required is based on the business impact of the critical operations, sites, assets and their inherent vulnerabilities.

Internal and external factors continually change business processes as well as risks, so the Program also includes lifecycle maintenance, testing and third-party validation.

The Program strategy integrates core planning assumptions in plan development. They are:

- The incident/disaster which prompted the recovery process affects only internal business function(s) and/or site(s) – certain other public services infrastructure (fire, ambulance, police, etc...) remain intact.
- Worst-case scenario is total disruption. If the actual disaster is not worse-case scenario, procedures will be modified within the appropriate strategies to only cover those critical business function(s) and processes affected by a disaster.
- Up to 50% of the function's staff at a particular site may be unavailable for work following the disaster. The disaster may affect multiple sites within a regional area.
- The off-site storage location in unaffected by the disaster since geographical proximity and accessibility were considered in site selection which minimizes the potential for the same disaster impacting both locations

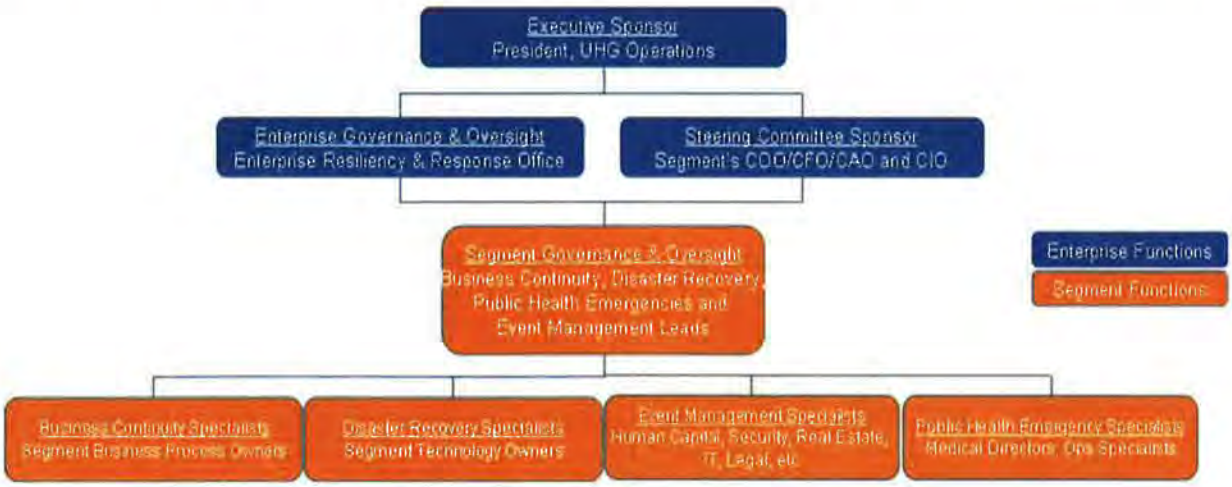
- Operating efficiency will be reduced during the recovery and stabilization periods. Processing will take longer and/or there may be greater instances of human error during survival-mode operation of the business function(s).

The Layered Program Model

The layered Program model is focused on ensuring consistency between the organization's event management, site emergency response, business continuity, disaster recovery and public health emergency planning efforts. These layers are interrelated and work together to provide maximum protection and risk mitigation. The model is built upon the following key components:

Organizational Accountabilities and Governance

The Program is implemented through an organization structure that requires active participation among all business stakeholders; including technology and business operations. The Enterprise Resiliency & Response Office, together with the Enterprise Resiliency & Response Steering Committee, comprised of corporate and segment executives, have the responsibility for defining the recovery project initiatives, oversight and support of the program which is in compliance with regulatory guidelines and customer expectations. Through the Program, the segments have responsibility and accountability to sustain the organization's capacity and readiness to manage a major incident or disaster through to resolution.



Section II - Event Management Plan

Event Management Strategy

Effectively managing a crisis situation through to resolution in a large organization requires more rapid decision-making and communication process than is used for normal day-to-day business operations. As a result, the UnitedHealth Group event management plan outlines the management organization (event management team) and communication process to be utilized to facilitate a timely response to major events affecting our personnel, business operations, and site locations, with the goal of avoiding or minimizing damage to the organization's ability to serve patients, members, customers and key stakeholders.

This plan identifies the event management team and outlines their key roles and responsibilities. The event management team is collectively responsible for managing the situation and making the critical decisions that drive remediation and coordination with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization. The event management team also supports execution on the event management decisions and provides central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.

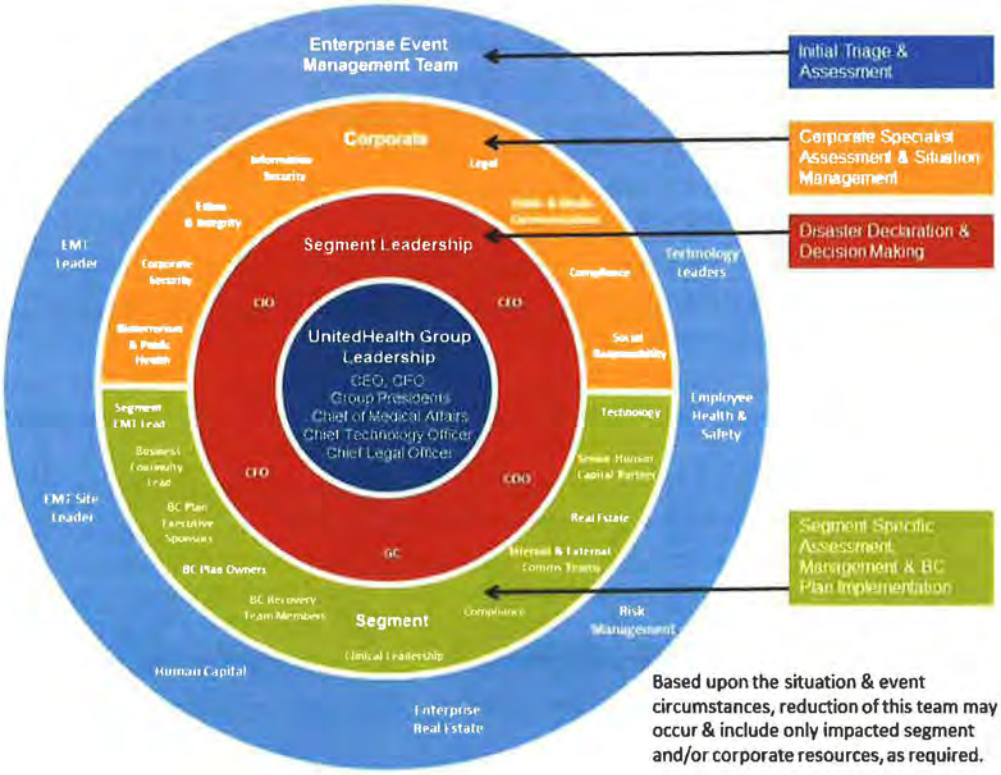
The event management plan has been established to provide a framework to facilitate the effective response and recovery of a major event. This plan provides the structure for:

- UnitedHealth Group's event management team;
- Event management process, including identification, escalation, notification and response channels as well as roles and responsibilities of the event management team;
- Established standards and checklist for the event management team, including, but not limited to: command center activation; damage assessment of people, information and property; risk management and safety; technology impact and response; and, employee, media and customer communications; and
- Disaster declaration standards

Event Management Team

The primary purpose of the event management team is to provide a consistent and reliable approach for communication and engagement between all required parties necessary to manage a major event. Subject matter experts, both at the corporate and segment level, continue to manage actions within their functional teams, however, will leverage the event management team as a forum to more quickly and reliably engage, communicate and make decisions between teams. The event management team:

- Consists of corporate and segment leadership with responsibility for event communication and response execution.
- Engages required executive leadership necessary to respond to the event.
- Executes on the decisions made by executive leadership and provide central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.
- Determines the strategy for how an event will be managed effectively and efficiently through to resolution. Responsible for facilitating the critical decisions that drive the remediation and coordination efforts with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization.
- Comprised of the following functional leaders or appropriate alternatives, as required:



Section III – Site Emergency Response

Site Emergency Response Strategy

To support and facilitate a coordinated and controlled building occupant response in an emergency, UnitedHealth Group policy requires all offices with over 10 employees have a site Emergency Action Plan (EAP). These plans focus on the immediate site needs during an emergency, such as employee evacuation and public services engagement. The company's emergency response team is often the first responder to a situation and help ensure that employees remain safe, sheltered and their basic life/safety needs are met.

Emergency action plans are used in conjunction with the event management process.

Site Emergency Planning Standards

To help ensure consistency and effectiveness, the site emergency action plans are developed using standard tools and templates. The following provides a high-level description of each of the sections contained within the individual site plans:

Purpose – The purpose of the Emergency Action Plan.

Location Information – Information pertaining to the physical location including building address and primary contact phone numbers.

Emergency Contact Information – A list of key phone numbers including emergency services, Facilities Management and Security, where applicable.

Site Emergency Response Team Roles and Responsibilities – Specific roles and responsibilities as defined including Event Management Team Site Lead, Emergency Response Team Site Lead, Floor Marshals, and Facilities Management.

Emergencies that may Result in Business Interruption or Office Closing – Procedures to engage the Event Management Team.

One Breath Situations – Procedures to engage Human Capital, where applicable.

Medical Emergencies – Specific procedures to respond to medical emergencies including location and contents of first aid supplies.

Fire(s) – Specific procedures pertaining to fires within the building including building alarm sounds, high rise procedures (where applicable), evacuation maps and post evacuation assembly areas.

Severe Weather – Specific procedures to respond to severe weather events including monitoring/notification procedures and areas to shelter-in-place.

Additional Hazard-Specific Procedures - if applicable, including but not limited to: Facility Related Emergencies; Criminal, Terroristic or Violent Behavior; Bomb Threats; Suspicious Packages; Civil Disturbances or Demonstrations; Hazardous Materials Exposures or Release; Biohazard Exposures or Release, and Earthquakes.

Lifecycle Maintenance

Change Management and Update Process

In order to maintain an effective Program, site emergency response plans are updated annually and monitored for compliance by the Risk Management and Safety organization.

Testing

The site emergency action plans are tested at a minimum annually through drill techniques including fire, severe weather and/or earthquake. Drills may include tabletop (practical or simulated exercise), structured walk-through (functional), and/or large or full-scale (live or real-life exercise).

Section IV - Business Continuity Planning

Risk Assessment & Management

Business continuity planning requirements are driven by a business impact analysis, supporting the company's Enterprise Risk Management discipline as an integral part of UnitedHealth Group's culture, decision-making processes, and governance processes. The business impact analysis, combined with threat and risk assessments, helps assure that business continuity risks are appropriately prioritized and remediated by applying cost effective strategies and mechanisms to reduce risk to a tolerable level. The enterprise business impact analysis process:

- Identifies potential impact of uncontrolled, nonspecific events on UnitedHealth Group business processes and its customers;
- Considers all business segment functions; and

- Provides an estimation of maximum allowable downtime and acceptable levels of data and operational loss.

Each critical function is required to perform a risk assessment utilizing the business impact analysis, threat and vulnerability assessment, and gap analysis of business continuity mechanisms currently in place. The end result of this risk assessment is a segment commitment to reduce risk to an acceptable level within reasonable resource and budgetary constraints.

This risk-based approach further optimizes business continuity planning by creating common definitions, defining standards and best practices and using common recovery strategies to meet the business requirements.

Business Continuity Plan Strategy

The business continuity plans are part of the overall program designed and structured to respond to disaster events, restore critical business function processes, and resume normal business function operations in a prioritized manner. The plans focus on critical business functions and planning for the worst-case scenarios so that we can react quickly and efficiently. These worst-case scenarios cover impacts from all types of disasters, both natural and man-made.

The following scenarios are provided as planning recovery objectives:

- Loss of Facility - Complete interruption of facilities without access to its equipment, local data and content. The interruption may impact a single site or multiple sites in a geographic region. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.
- Loss of Critical Resources - Complete interruption with 100% loss of personnel within the first 24 hours and 50% loss of personnel long-term. The interruption may impact a single site or multiple sites in a geographic area. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.
- Loss of Critical Systems - Complete interruption and/or access of critical systems and data located at the various UnitedHealth Group Data Centers for an extended period of time. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.
- Loss of Critical Vendors - Complete interruption in a service or supply provided by a third-party vendor(s). Recovery from anything less than complete interruption will be achieved by using appropriate portions of the plan.

Having clearly defined the business recovery objectives, UnitedHealth Group developed recovery strategies needed to meet these objectives. These recovery strategies vary between Business Segment and the overall criticality rating of the business function or process, which in turn provides guidance on a minimum recovery time objective.

Business functions which are classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed redundant operations and maintain a recovery time objective of 72 hours or less. UnitedHealth Group's critical business functions include, but not limited to, healthcare delivery, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations and core corporate functions.

A variety of business continuity strategies are deployed depending on the business function, criticality ranking and established recovery time objectives. These strategies include:

- Resilient operations - include dual site operations and continuous availability solutions. In the event of an interruption at one site the business function is transferred to one or more alternate locations at which staff and facilities are already prepared to handle it.
- Remote working - includes the concept of "working from home or telecommuting" and working from other non-corporate locations through secured connections.
- Multiple shifts – makes alternate space available to greater number of staff by dividing staff into two shifts (e.g., morning and evening).
- Buddy up - makes use of existing in-company accommodation such as a training facility or lunch rooms to provide recovery space or increasing the office density.
- Off-loading – consists of off-loading additional critical tasks to staff at available sites or staff cross-trained to perform that function. .
- Displacement - involves displacing workspace used by staff performing less urgent business processes with staff performing a higher priority activity.
- A "do nothing" strategy may be acceptable for certain non-urgent functions identified in the business impact assessment.

Business Continuity Program Development Standards

To help ensure consistency and effectiveness, the business continuity plans are developed using standard tools and templates. The following provides a high-level description of each of the sections contained within the individual business continuity plans:

Plan Intro, Plan Overview and General Recovery Standards:

- Standards for document use, intended audience, plan availability and distribution.
- Plan objectives, assumptions, scenarios and life-cycle maintenance, review and updated procedures and budget guidelines.
- General Recovery Standards – including disaster response, assessment, disaster declaration standards, command center activation, as well as internal and external communication standards

Business Recovery Overview:

- Uses the results of the business impact analysis to define the business process criticality and prioritization, recovery time objectives, and overall business function recovery strategy. Defines the recovery sustainability analysis for loss of critical facility, loss of critical resources, loss of critical system and loss of critical vendor.
- Defines the recovery checklist, chain of events, critical tasks and detailed steps that need to be taken to stabilize operations in survival-mode and restore the business function processes in order of their criticality.
- Establishes the process for plan evaluation and defines the detailed steps for evaluating the business continuity plan performance to learn from the experience and enhance our business function preparedness and capabilities to respond and recover more effectively and efficiently.

Remaining BC Plan Sections"

- *Process Details* – Provides key impact metrics utilized during prioritization analysis
- *Function, Segment and Enterprise Recovery Teams* – Identifies team members with responsibility to execute and coordinate recovery activities defined in the BC Plan.
- *Call List* – Provides the call sequence and emergency contact information of individuals to start the call tree.

- *Segment Interdependencies* – Defines the business function's critical dependencies on other UnitedHealth Group business functions/processes
- *Critical Applications* – Defines the business function's critical dependencies on UnitedHealth Group systems/applications
- *Locations* – Defines the main locations, alternate recovery and command center locations used by the business operations
- *Critical Customers, Regulators and Other Third Parties* – Identifies the critical external stakeholders and/or communication process to be used at the time of the event.
- *Critical Vendors* – Identifies the critical vendors and/or suppliers the business requires to sustain operations
- *Critical Equipment* – Defines the business function's minimum equipment configuration needed to sustain operations
- *Vital Records* – Defines the specific vital records stored offsite, as well as their storage location and contact information to use to retrieve them during a disaster.

Lifecycle Maintenance

Change Management and Update Process

Change is inevitable in any organization. Applications, infrastructure, function alignments, customer, vendors, site and contacts must continually be monitored and updated. In order to maintain an effective Program, business continuity plans are updated a minimum of twice annually and monitored for compliance by the Enterprise Resiliency & Response office.

Metrics and Measurements

The Program metrics and reporting provide status and information necessary to manage current and future efforts. Key performance indicators are used to derive the "health" of the business continuity plans. Annually, each segment is required to provide executive sign-off on the certification of the plans. This reporting is delivered and reviewed by the Program Steering Committee and the Executive Sponsor to help ensure compliance with the Program strategy.

Testing and Certification

The business continuity plans must be tested at a minimum annually through a variety of exercises formats, using scenarios that vary annually. Exercises may include structured walk-throughs, call tree validation, tabletop event simulation, and large or full-scale simulations. The Program uses an exercise roadmap to track what scenarios have been exercised in the past to ensure each exercise introduces a new situation that challenges the recovery team.

A formal test exercise report, identifying any gaps, issues and/or enhancements identified through testing, is published and monitored for remediation. When the remediation plan is complete, the plan is certified by the appropriate Executive Leadership. This certification process is monitored by the Program Steering Committee.

Section V - Disaster Recovery Planning

Disaster Recovery Objectives

UnitedHealth Group relies on a diverse array of interconnected information systems to meet the needs of its clients. The goal of disaster recovery (DR) planning is to protect the organization in the event that all or key aspects of UnitedHealth Group operations are rendered unusable. Preparedness is the key. The company has instituted an Enterprise Disaster Recovery Program (the Program) to first eliminate or reduce disaster risk in critical technology areas, and then plan for facilitation and the timely and predictable restoration of key applications, data, and supporting critical infrastructure.

The mission of the Program is to minimize the aggregate risk and impact to UnitedHealth Group from the occurrence of disaster events, focused on the overall viability of UnitedHealth Group to survive an event.

Following are the objectives of the Program that are in support of the mission:

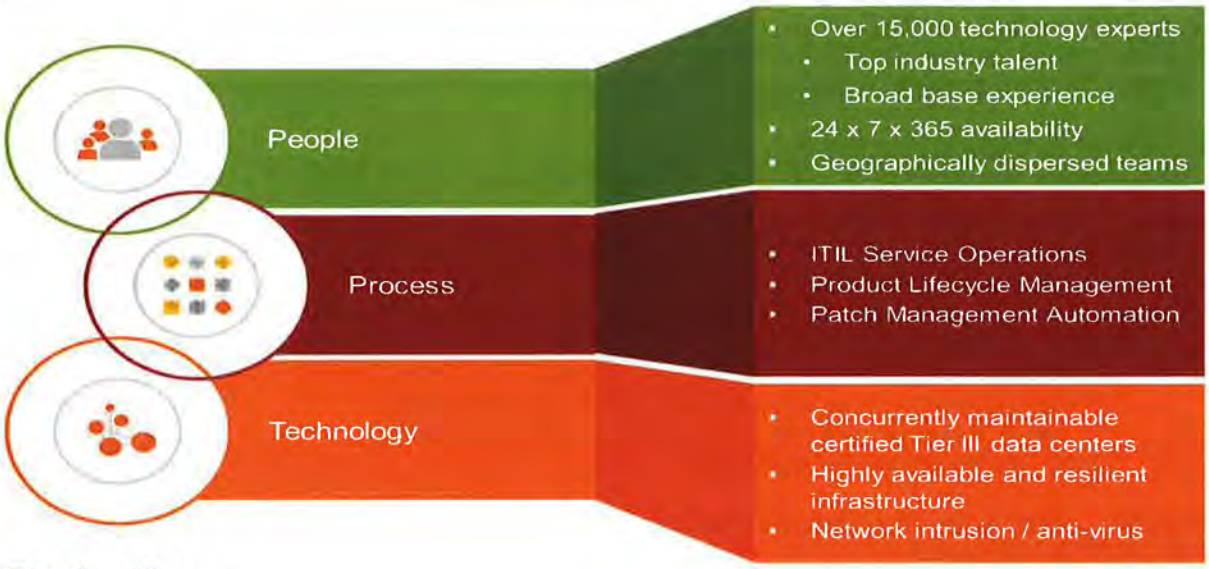
- Provide a "systems solution" that accommodates the interdependencies between business processes and applications (i.e., recover the entire business transaction)
- Drive systemic and measurable improvements in DR capability (e.g., business process Recovery Time Objective (RTO))
- Recognizing funding and time constraints, evolve and improve the DR capability in a manner that provides greatest good for greatest number
- Establish DR requirements as part of UnitedHealth Group's systems architecture, delivery and operations as opposed to an after-thought once a new application goes into production
- Develop and deploy a modular, adaptive set of capabilities rather than one size fits all
- Deal with the most probable DR scenarios in addition to worst case "smoking hole"
- In addition to protecting UnitedHealth Group's on-going viability, make the DR capability a competitive strength that can be leveraged in the market.

Disaster Recovery Strategies

UnitedHealth Group's approach to DR is based on the two fundamentals: Prevention and Protection. A focus on balancing the combination of disaster prevention and protection results in reducing both the probability and impact of a disaster. The Program first eliminates or reduces disaster risk in critical areas, and then plans for the most probable disaster scenarios.

Prevention

For many companies, disaster recovery means minimizing downtime as they try to restore systems and get them back online. Our strategy includes focusing on items that would assist in preventing a disaster from taking down systems in the first place. The corporation has invested in creating an effective combination of people, process and technology that provides the fundamentals for a proven production method resulting in a stable, scalable environment for our applications to perform at operational excellence. This investment creates the "prevention" which is fundamental to the Program. Prevention is the proactive remediation of known technology exposures. Prevention includes removing the "accidents just waiting to happen".



Protection

Completely avoiding a technology disaster is impossible. However, the Program is based on anticipating and planning for the common types of disasters and designing solutions to address them. Disaster Protection addresses recovery from the most probable disaster scenarios and a worst case "smoking hole" scenario.

Highlights of the disaster recovery protection components include:

- The UnitedHealth Group Technology data centers can operate in a "Lights out" mode for up to 3 days. If the Data Center continues to get fuel to run the generators, they are designed to run in this mode indefinitely.
- Operational backups are designed to use high performance disk-to-disk primary copy with physical offsite second copy tape.
- DR Active and DR Standby recovery solutions employ Active-Active and/or Active-Standby components located in two geographically separate data centers where either site can fully support the production application in the event of a disaster with minimal manual intervention.
- Mainframe SAN Replication recovery solution employs full asynchronous data replication between the production mainframe and a geographically dispersed hot standby DR mainframe.
- Distributed SAN Replication recovery solution employs full asynchronous data replication of production storage pools for distributed systems (UNIX and Wintel) and failover of production processing to geographically dispersed non-production systems for processing.
- uCI Array Replicated storage in the Optum Cloud environment utilizes VMware Site Recovery Manager (SRM) to replicate entire Virtual Machine (VM) through full asynchronous SAN replication to an alternate data center with Virtual recovery to available capacity.
- Some distributed systems employ a Hot recovery solution with failover of production to geographically separate non-production systems utilizing virtual tape or tape data restoration.
- Each critical application has a DR Plan that is refreshed at least once each year and tested annually.
- Metrics in the form of Key Risk Indicators (KRIs) are used to derive the "health" of the EDR program.

The UnitedHealth Group DR strategy involves identifying critical business processes and transitioning these critical applications, data, and supporting infrastructure to an alternate recovery location in a timely manner, thereby reducing the impact of a technology event to our critical business clients.

A variety of recovery strategies are utilized which align to the defined criticality of the application. Business critical applications, as defined by the business impact analysis and subsequent business continuity plan, are given the highest priority and generally have a 72 hour or less recovery time objective.

Lifecycle Maintenance

Existing DR Plans follow standard lifecycle maintenance and are refreshed at least annually and as changes occur. It is the responsibility of Application Owners and the Enterprise DR Team to ensure Plans are reviewed to identify:

- Equipment updates
- Employee changes (resignations and terminations)
- Changes in business requirements not reflected in specific plans
- Third party preparedness to validate against contractual obligations
- Inaccurate assumptions or oversights

Application disaster recovery plans are approved and certified annually by the appropriate Information Technology Senior Leader.

Section VI – Public Health and Pandemic Planning

Objectives

As a health and well-being company, we believe it is critical to plan for events that impact public health, including pandemics and the potential impact to our customers, members, providers and our own operations. Natural disasters such as hurricanes, wild fires and pandemics can expand very quickly and arrive with little or no warning; therefore companies need to be vigilant and prepared. We recognize the need to provide ongoing access to health care for our members and customers who may be impacted by these events. Pandemics can spread very quickly, so understanding what we need to address in advance, and being prepared to readily implement these actions will help sustain our operations and minimize impact to our customers during a pandemic or other public health event. .

UnitedHealth Group plans for such public health events within the Enterprise Resiliency & Response Program to ensure the availability of critical services for our customers. Individual business continuity plans require planning for a loss of 50% of personnel, loss of facilities, critical vendors and loss of or disruption to our technology. The event management plan provides the command and control structure to ensure effective monitoring, communication and decision making during the emergency. Information technology disaster recovery plans are in place to manage any impact to technology infrastructure and applications that could negatively affect our ability to serve customers, physicians, members, and others. As a national company with vast local resources, we have geographically dispersed computing, customer service facilities and health care networks that can support and supplement the work of compromised localities.

Where a pandemic involves a virulent strain, we may experience a surge in the need for our services, but may simultaneously see a reduction in our ability to provide these services. Therefore, pre-planning is critical to address any adverse impact to our services and systems from anticipated demands. During a pandemic, health services access will likely be altered from the services that are provided now. For example, demand for elective medical and surgical procedures will probably decrease; demand for acute care services in emergency departments and hospitals will likely increase. Public health officials will have the responsibility of triaging and prioritizing where, when and how health services will be provided.

We will work in collaboration with local and state health department officials to disseminate information on the availability of health services and will adhere to the public health direction on prioritization efforts for the provision of such services during public health emergencies. We will use our communication vehicles,

including print and electronic media, to make information on provisions and availability of services widely accessible to our members, as well as members of the broader community where we operate.

We are committed to providing our customers, physicians who contract with us, members and others with timely clinical information. We will work to ensure that benefit designs and their interpretation will facilitate socially and medically appropriate access to clinical care, medical supplies, vaccines and pharmaceuticals. For example, we will assure that quantity limits for antiviral medications used to prevent and treat influenza are consistent with recommendations of the Centers for Disease Control and Prevention (CDC).

Clinical Resources

With over 30,000 physicians, nurses, and clinical practitioners directly on our staff, we have the national and local resources to respond quickly and effectively during a public health crisis. The event management team serves as the vehicle to provide our customers with timely clinical information based upon CDC guidance, expert health professionals' input, and our real-time experience in serving more than 137 million people globally. This team is also responsible for reviewing and providing any information that is relevant to changes in UnitedHealth Group policies and procedures that may affect customers, members and clinical partners.

We can support federal, state, and local health department disease surveillance activities to identify and track disease outbreaks through data on emergency room usage, visits to physicians for a particular illness, and the filling of prescriptions.

As we have seen during the H1N1 pandemic, and impact of major hurricanes, flooding and wild fires, health services access may be altered in a public health crisis from the services that are provided during normal times. Public health officials will have the responsibility of triaging and prioritizing where, when and how health services will be provided. Epidemiologically-based decisions will be made to provide critical services in appropriate places. For example, depending on the severity of the situation:

- Hospital care will probably be limited to those who are most critically ill from the pandemic and from other conditions. Services to those who are immunocompromised will not be provided in the same facilities as services for those who are critically ill with infection from a pandemic virus.
- Emergency medical services will be triaged by public health officials. We will work in collaboration with these agencies to ensure that our members, as well as all persons in the community, have access to appropriate health services. Non-pandemic-related medical care that is now delivered in the emergency room likely will be delivered in other settings

UnitedHealth Group's locally-based Market Medical Directors have established relationships with local health care providers, local medical societies, state medical licensure boards and state and local health departments. Regardless of the cause of the public health emergency, our medical directors work in collaboration with public health agencies to help ensure access to care in the event of a public health emergency. Relationships are also well-established with regulators and other government agencies, our customers, members and local community groups. Our medical directors work in collaboration with public health agencies and non-governmental organizations, such as the American Red Cross, to help ensure access to care for our members in the event of a disaster.

Approach

UnitedHealth Group has established procedures for handling emergency management situations including: initial assessment of the severity of the situation; prioritization of actions needed to resolve the immediate care needs of our members; development of an action plan, which includes assigning

resources for implementation; implementation of action plan, including continuous monitoring; documenting successful interventions; and validation of successful intervention.

Our Event Management Team monitors for impending disasters such as those caused by hurricanes and flooding and proactively mobilizes the appropriate planning and response resources to address the needs of our business, members and providers.

The Public Health Event Management Team assesses the risk and engages both enterprise-level executives and local healthplan leadership to mobilize a complete response. Leaders engaged in the response may include healthplan CEO's, Medical Directors, Provider Services, Member Services, Communication Specialists, Compliance Officers, and others as appropriate. The Public Health Event Management Team convenes to discuss the current situation and defines actions to be taken, resources to be deployed, and specific timeframes and touch points for monitoring to ensure continuous communication and care continuity for members and providers.

Each event is unique and our response is customized based on need and based on the services UnitedHealthcare provides to members in the impacted area. The following activities may be included as part of our overall efforts:

- Medical benefits may be temporarily modified to assist members preparing for, or responding to, the disaster in order to ease access to healthcare. These actions may include: removing prior authorization/notification requirements, allowing early refills of prescription medication, easing restrictions on use of out-of-network providers and providing early replacement of Durable Medical Equipment (DME).
- The Optum Crisis Counseling line may be made available to the community as a whole to provide mental health support to those who may need it. This service is free of charge and open to anyone impacted by the event.
- Our local clinical directors collaborate to identify members currently hospitalized or at long-term care facilities, evaluate the provider capacity within the geographic area, and where appropriate, identify reassignments and communicate this information to members and providers.
- Our Medical Directors review case management and disease management files to identify members at most risk due to disease severity or fragility. These members are a priority to contact to arrange for care continuity and determine if they need evacuation assistance.
- UnitedHealthcare and Optum's post-acute care patients are identified and our care managers ensure adequate supplies and prescriptions medication are available. In the event the member is to be evacuated, appropriate sites and resources are identified that will meet the transportation and ongoing needs of individual.
- We often provide financial support, both proactively to strengthen communities, and as part of our post-disaster community response.
- UnitedHealth Group employees and local leaders often participate in community recovery and rebuilding efforts as part of our social responsibility efforts to support the communities in which we work.
- Our compliance team proactively searches for any regulatory orders related to the event, such as state-level Executive Orders, Department of Insurance Orders or federal-level HHS or CMS orders, to ensure we are addressing all regulatory requirements.

Section VII - Conclusion

In support of UnitedHealth Group's mission to help people live healthier lives and help the healthcare system work better for everyone, we are committed to providing vital services to our members and community during times of calm as well as crisis. The Enterprise Resiliency & Response Program, with the interrelated services of event management, site emergency planning, business continuity planning,

disaster recovery planning, and response to events impacting public health and pandemics , are designed to ensure we can react quickly to all forms as disasters, minimizing potential negative impacts to our operations and vital services.

If additional information is required regarding any component of this program, please direct questions to your account executive team, or regulatory officer.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: ABC Company

Policy Number: 123456

Effective Date: January 1, 2019

Premium Due Date: January 1 and the first day of each month thereafter

Policy Anniversaries will be each January 1

We, UnitedHealthcare Insurance Company, agree to provide, for eligible persons becoming insured under the Policy, the benefits according to the terms, provisions and limitations of it. The following pages, including any riders, endorsements or amendments, are part of the Policy.

The Policy is issued in consideration of the Policyholder's application, a copy of which is attached.

The Policy becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above. The Policy will continue in force by the payment of premiums when due. The Policy is subject to termination according to its terms.

Read the Policy Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

The Policy is issued in and governed by the laws of the State in which it is delivered.

We have, by its President and Secretary, executed the Policy at Hartford, Connecticut. If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

Secretary

President

Group Life, Accidental Death and Dismemberment, Working Returns
Short Term Disability, Working Returns
Long Term Disability Insurance Policy
Non-Participating

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

POLICY GENERAL PROVISIONS

Certificates: The Policyholder will be furnished with a Certificate for delivery to each Covered Person. The Certificate(s) describe the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Conformity With State or Federal Statutes: If any provision of the Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

Entire Group Contract: The entire Group Contract between the Policyholder and Us consists of the Policy, Certificate(s), amendment(s) and the Policyholder's application (a copy of which is attached). All Certificate(s), riders, endorsements and any amendments are listed on the Policy Contents page.

All statements made by the Policyholder and by any Covered Person are representations and not warranties. No statement made by the Covered Person will be used to contest the insurance provided by the Policy, unless:

1. it is contained in a written statement signed by the Covered Person; and
2. a copy of the statement is furnished to the Covered Person or beneficiary.

Only We may change the Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by Us. Any change so made will be binding on all persons referred to in the Policy. No agent has the authority to change the Policy or waive any of the provisions. For purposes of the Policy, the Policyholder acts on its own behalf, or as the Covered Person's agent. The Policyholder is not an agent of Ours.

Nonparticipation: The Policy will not be entitled to share in Our surplus earnings.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at Our Home Office. A Grace Period of 31 days from the Premium Due Date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will remain in effect provided the premium is paid before the end of the Grace Period. Payment of Premium for a period before it is due will not guarantee that the insurance will remain in effect for that period.

Premium Rate Change: We have the right to change premium rates as of any Premium Due Date but not more than once in any 12-month period. We will notify the Policyholder in writing at least 60 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more;
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Termination of the Policy: The Policy may be canceled by either the Policyholder or Us.

1. The Policy will be cancelled if any of the following occurs:
   a. the Policyholder does not provide Us with information that We need to administer the Policy;
   b. the Policyholder fails to perform any of its obligations that relate to the Policy;
   c. the date the number of Covered Persons decreases to less than 2;
   d. the Policyholder fails to pay premium within the Grace Period.
2. We may cancel or offer to modify the Policy if any of the following occurs:
   a. less than 75% of all eligible Employees are participating, if the Employer contributes partially towards the cost of insurance;
   b. less than 100% of all eligible Employees are participating, if the Employer contributes in whole towards the cost of insurance;

The Termination of an Insurance Option under the Policy: We may cancel or modify any Insurance Option if the number of Employees insured falls below the greater of:

1. 10 Covered Persons; or
2. 10% of all eligible Employees.

The Policyholder must pay Us all premium due for the full period the Policy is in effect. We reserve the right to review and terminate all classes insured under the Policy, if any class(es) cease(s) to be insured.

POLICY CONTENTS

All of the provisions in the Certificate(s) of Coverage, riders, endorsements and any amendments issued for the Policyholder shown below are included and made part of this Policy.

DOCUMENTS	DESCRIPTION	EFFECTIVE DATE
Group Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability Certificate Of Coverage	All active full-time Employees	January 1, 2019
Certificate Modifications Rider	Amends the contract as outlined	January 1, 2019

UnitedHealthcare®
Specialty Benefits℠

GROUP SHORT TERM DISABILITY CERTIFICATE OF COVERAGE

FOR

ABC COMPANY

POLICY NUMBER: 123456

EFFECTIVE DATE: January 1, 2006

Any State

(11-05)

TABLE OF CONTENTS

United HealthCare Insurance Company

450 Columbus Boulevard

Hartford, Connecticut

(Home Office)

Policyholder: ABC Company

Effective Date of Policyholder: January 1, 2006

Policy Number: 123456

Covered Person: As on file with the Administrator

Certificate Number: As on file with the Administrator

Certificate Effective Date: As on file with the Administrator

We, United HealthCare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person eligible for insurance.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder, or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

It is signed at the Home Office of United HealthCare Insurance Company as of the Effective Date shown above.

Matthew Friedman

Secretary

President

Group Working Returns
Short Term Disability Insurance Policy
Non-Participating

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

SCHEDULE OF BENEFITS

Class of Employees
This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

All full-time Employees, excluding temporary and seasonal employees

Description of Class:

Employees are considered full-time if they customarily work: 30 hours per week

Employee Waiting Period:

An Employee is eligible for insurance on the later of the following dates:

1. The Group Policy's Effective Date, January 1, 2006
2. The first day of the month following the date the Employee completes 30 days of continuous employment with the Policyholder.

If the Covered Person's employment ends and the same employer rehires him within one year, We will apply his previous employment in an eligible class toward completing the Waiting Period.

Covered Person Insurance:

Short Term Disability Benefit:

Benefit Percent: 60% of the Covered Person's Pre-Disability Weekly Earnings. The Covered Person's benefit may be reduced by Other Income Benefits and Disability Earnings.

Pre-Disability Weekly Earnings Definition:
The average weekly earnings received from the Covered Person's employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings include commissions, averaged over the lesser of the most recent 24-month period or the Covered Person's period of employment. It does not include bonuses, overtime pay, and other extra compensation.

Maximum Weekly Benefit: $1,000

Minimum Weekly Benefit: $25

Elimination Period:	For Disability due to Injury:	7 days
	For Disability due to Sickness:	7 days
Maximum Benefit Period:	26 Weeks of benefits Premium contributions must continue while the Covered Person is receiving Short Term Disability payments.	

STD Benefits are issued on an:
☐ occupational (24 hour) basis ☒ non-occupational basis

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave.)

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Dependent: Includes

1. a legal Spouse including a Domestic Partner; and
2. any unmarried Child.

A Child is:

1. less than 19 years of age; or
2. an Eligible Student;
   a. who is not married;
   b. who is not in the armed forces of any country;
   c. who is not insured under the Policy as a Covered Person;
   d. who is less than 25 years of age;
   e. who attends an accredited post-secondary school (other than a correspondence school) on a full-time basis as defined by the post-secondary school; and
   f. is enrolled in the next scheduled term.

   or

3. physically or mentally Disabled.

The term "Child" includes a natural child, legally adopted child, stepchild, foster child, or any child who lives with the Covered Person in a regular parent-child relationship, provided the Covered Person claims such Child as a Dependent on the Covered Person's most recent federal income tax return.

Employee: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

GENERAL DEFINITIONS (continued)

No director or officer of the Policyholder will be considered an Employee unless he meets the above conditions.

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: A bodily Injury resulting directly from an accident and independently of all other causes.

Physician: A practitioner of the healing arts who is:

1. duly licensed in the state in which the Treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's spouse, children, parents, parents-in-law, or siblings.

Regular Care: The Covered Person personally visits a Physician as often as is medically required to effectively manage and treat his disabling condition(s), according to generally accepted medical standards. The Covered Person is receiving appropriate Treatment and care, according to generally accepted medical standards, by a Physician whose specialty or experience is appropriate for the disabling condition(s).

Sickness: An illness, disease, pregnancy or complication of pregnancy.

Treatment: consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: United HealthCare Insurance Company.

CERTIFICATE GENERAL PROVISIONS

Discretionary Authority: When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's or Dependent's eligibility, if applicable, for benefits and to interpret the terms and provisions of the Policy. This provision applies, however, only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Misstatement of Age: If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at Our Home Office. A Grace Period of 31 days from the Premium Due Date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will remain in effect provided the premium is paid before the end of the Grace Period. Payment of Premium for a period before it is due will not guarantee that the insurance will remain in effect for that period.

CERTIFICATE GENERAL PROVISIONS (continued)

Premium Rate Change: We have the right to change premium rates as of any Premium Due Date but not more than once in any 12-month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more;
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Workers' Compensation laws.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
    a. the date the Employee is eligible for insurance, regardless of when he applies; or
    b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

Effective Date of Change in Amount of Insurance: If there is an increase in the amount of the Covered Person's insurance, the increase will take effect on:

1. the first day of the month on or next following the date of the increase, if the Covered Person is Actively at Work on the date of increase;
2. the date the Covered Person returns to Active Work if the Covered Person is not Actively at Work on the first day of the month on or next following the date of the increase;
3. the first day of the month on or next following the date of the increase, if the first day of the month is a non-working day and the Covered Person was Actively at Work on his last scheduled working day before the non-working day;
4. the date of the increase if the Covered Person is on an approved layoff or leave of absence, for reasons other than a Sickness or Injury.

If evidence of insurability is required, the increase will take effect on the later of the dates indicated above or the date We approve his application.

A decrease in the amount of the Covered Person's insurance will take effect on the date of the decrease.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his employer's policy on Family and Medical Leaves of Absence.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his employer.

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his employer just prior to the date his Leave of Absence started to determine Our payments to him.

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date he ceases to be Actively at Work. If active work ceases the Policyholder may deem the Covered Person's employment continued during a temporary layoff or approved leave of absence. In such case, insurance will not continue beyond the end of the month following the month in which the layoff or leave began.
6. the date he is no longer Actively at Work due to a labor dispute, including but limited to strike, work slow down or lock out.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

The Covered Person is Disabled or has a Disability when We determine that:

1. he is not Actively at Work and is unable to perform some or all of the Material and Substantial Duties of his Regular Occupation due to his Sickness or Injury; and
2. he has a 20% or more loss in Pre-Disability Weekly Earnings due solely to the same Sickness or Injury.
3. he is under the Regular Care of a Physician.

Material and Substantial Duties: duties that

1. are normally required for the performance of the Covered Person's Regular Occupation; and
2. cannot be reasonably omitted or modified.

Regular Occupation means: the occupation which the Covered Person is routinely performing when his Disability occurs. We will look at the Covered Person's occupation as it is normally performed in the national economy instead of how the work tasks are performed for a specific employer or at a specific location.

Disability must begin while the Covered Person is insured under the Policy.

The loss of a professional or occupational license or certification, work permit, or visa does not, in itself, mean the Covered Person is Disabled. Additionally, economic factors, such as recession, job obsolescence, pay-cuts and job sharing will not be considered in determining whether the Covered Person meets the definition of Disability/Disabled.

We require the Covered Person to be under the Regular Care of a Physician for the Sickness or Injury causing his Disability in order to be eligible to receive payments from Us.

We may require the Covered Person to be examined by Physicians, other medical practitioners or vocational experts of Our choice. We will pay for these examinations. We can require examinations as often as it is reasonable to do so. We may also require the Covered Person to be interviewed by an authorized representative of Ours. Refusal to be examined or interviewed may result in denial or termination of his claim.

Calculating the Weekly Payment:
The Benefit Percent and Maximum Weekly Benefit are shown in the Schedule of Benefits.

1. If the Covered Person is disabled and not working or working and earning less than 20% of his Pre-Disability Weekly Earnings, the Covered Person's Weekly Payment will be determined as follows:
   a. Multiply his Pre-Disability Weekly Earnings by the Benefit Percent.
   b. Compare the result in Step 1 with the Maximum Weekly Benefit.
   c. The lesser of these two amounts is the Covered Person's weekly Gross Disability Payment.
   d. Subtract from his weekly Gross Disability Payment any Other Income Benefit amounts that he receives or is eligible to receive. The result is the Covered Person's Weekly Payment.

2. If the Covered Person is disabled and working earning between 20% and 80% of his Pre-Disability Weekly Earnings, the Covered Person's Weekly Payment will be determined as follows:
   a. Multiply his Pre-Disability Weekly Earnings by the Benefit Percentage.
   b. From 100% of his Pre-Disability Weekly Earnings subtract any Other Income Benefits, and any income he earns or receives from any form of employment.
   c. Compare the result from Steps 1 and 2 with the Maximum Weekly Benefit.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

d. The lesser of the amounts from Step 3 is the amount We will pay the Covered Person each week.

After the Elimination Period, if the Covered Person is Disabled for only part of a week, We will send him 1/7th of his Weekly Payment for each day of Disability.

Gross Disability Payment means: the payment amount before We subtract Other Income Benefits and Disability Earnings.

Receipt of Disability Payments: The Covered Person will begin to receive payments when We approve his claim, provided the Elimination Period has been met and he is Disabled. We will send him a payment each week for any period for which We are liable. If he is Disabled and working, proof of Disability Earnings will be required before benefits are paid.

Disability Earnings mean: the earnings, which the Covered Person receives while Disabled, and working plus the earnings he could receive if he was working to his Maximum Capacity.

Maximum Capacity means: the greatest extent of work the Covered Person is able to do, given his limitations, restrictions, and physical and mental capacity, in an occupation that is available in his location and for which he is reasonably fitted by education, training, and experience.

Elimination Period means: the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability.

Hospital Confined or Hospital Confinement means: the Covered Person is admitted as an inpatient in a Hospital or Medical Facility for a period of at least 24 hours for the condition resulting in his Disability.

Disability During a Covered Layoff or Leave of Absence: If the Covered Person becomes Disabled while he is on a covered layoff or leave of absence, We will calculate his benefit using his Pre-Disability Weekly Earnings from his employer in effect just prior to the date his absence begins.

Other Income Benefits We will subtract from the Covered Person's Gross Disability Payment the following Other Income Benefits:

1. any benefits and awards he receives or is eligible to receive under:
   a. Workers' Compensation Law;
   b. occupational disease Law; or
   c. any other similar Act or Law.
   d. unless this insurance is issued on a non-occupational basis as shown in the Schedule of Benefits.

2. any Disability income benefits he receives or is eligible to receive under:
   a. any compulsory benefit act or Law;
   b. any other group insurance policy with the employer or with an association;
   c. any other group insurance policy with another employer under which he becomes covered while he is Disabled under the Policy; or
   d. any governmental retirement system as the result of his job with his employer.

3. any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, the Jones Act and any other similar plan or Act. Benefits include:
   a. Disability benefits he is eligible to receive and any disability benefits his spouse or his children receive or are eligible to receive as a result of his Disability.
   b. retirement benefits he receives and any retirement benefits his spouse or his children

receive as a result of his receipt of retirement benefits.

If the Covered Person's Disability begins after his 70th birthday, and he was receiving Social Security retirement benefits before his Disability began, then We will not reduce Our payments to him by these retirement benefits.

Pension Plan means: a plan that provides retirement benefits and which is not wholly funded by Employee contributions. The term does not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity plan (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.

4. any benefits he receives from his employer's sick leave or salary continuation plan.

5. any benefits from the employer's Retirement Plan he:
   a. receives as disability benefits;
   b. voluntarily chooses to receive as retirement benefits; or
   c. receives as retirement benefits once he reaches the greater of age 62 or normal retirement age, as defined in his employer's Retirement Plan.

   Regardless of how the retirement funds from the plan are distributed, for the purposes of determining Our payment to the Covered Person, We consider Employee and employer contributions to be distributed at the same time throughout the Covered Person's lifetime.

   We will not reduce payments the Covered Person receives from Us for his contributions to the employer's Retirement Plan, or for amounts he rolls over or transfers to an eligible Retirement Plan.

   Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

   Retirement benefits under a retirement plan are benefits that are paid based on the Covered Person's employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit.

   Eligible retirement plan is defined in Section 402 of the Internal Revenue Code of 1986 and includes future amendments to Section 402 affecting the definition.

6. any benefits for loss of time or lost wages he receives from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.

7. any amount he receives under any unemployment compensation Law, unless this insurance is issued on a non-occupational basis as shown in the Schedule of Benefits.

8. any amounts he receives from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

   If the Covered Person receives any of the Other Income Benefits in a lump sum payment, We will pro-rate the lump sum on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the Covered Person's Maximum Benefit Period.

Other Income Benefits must be payable as a result of the same Disability for which the Covered Person is receiving a payment from Us, except for retirement benefits.

We will NOT subtract from the Covered Person's Gross Disability Payment any amounts he receives from the following sources:

1. 401(k) plans
2. profit sharing plans
3. thrift plans
4. tax sheltered annuities
5. stock ownership plans
6. non-qualified plans of deferred compensation
7. Pension Plans for partners
8. military pension and military disability income plans
9. credit disability insurance
10. franchise disability income plans
11. a Retirement plan from another employer
12. Individual Retirement Accounts (IRA)
13. benefits from individual disability plans

Affect of Other Income Benefits on Payment: If subtracting Other Income Benefits results in a zero benefit, We will pay the Covered Person the Minimum Weekly Benefit shown in the Schedule of Benefits. The Minimum Weekly Benefit, however, may be applied toward an outstanding overpayment.

Estimating Amounts of Other Income Benefits: We have the right to estimate the amount of benefits the Covered Person may be eligible to receive under the "Other Income Benefits" section. We can reduce Our payments to him by the estimated amount if:

1. he has not been awarded but has not been denied such benefits; or
2. he has been denied such benefits and the denial is being appealed; or
3. he is reapplying for such benefits.

We will NOT reduce Our payments to the Covered Person by the estimated amount if:

1. he applies or reapplies for the benefits and appeals his denial through all of the administrative levels We believe are necessary; or
2. he signs Our reimbursement agreement form stating that he promises to pay Us any overpayment caused by an award.

If We reduce Our payments to the Covered Person by an estimated amount:

1. We will adjust Our payment to him when he provides proof of the amount awarded; or
2. We will issue a lump sum refund of the estimated amount if he was denied benefits and has completed all appeals (or reapplications) We believe are necessary.

Continuity Of Insurance Upon Transfer Of Insurance Carriers: In order to prevent loss of insurance for a Covered Person because of a transfer of insurance carriers, We will provide insurance for certain Employees as follows:

Employees who are not Actively at Work due to Sickness or Injury:

We will insure the Employee under the Policy if the prior group insurance policy insured him and the cost of his insurance under the prior group insurance policy was paid.

Our payments to the Employee will be limited to the lesser of the Weekly Payment under this Policy or the weekly payment the prior group insurance policy would have paid him, had that

policy stayed in effect. Our payments will be reduced by any amount the prior group insurance policy is responsible for paying.

If the Employee cannot satisfy the Pre-Existing Condition Exclusion test of either policy, then he will not be eligible for a Weekly Payment.

Recurrent Disability: If the Covered Person's current Disability is related or due to the same causes(s) as his prior Disability for which We made a payment, We will treat his current Disability as part of his prior claim. He will not have to complete another Elimination Period if he returns to Active Work for his employer on a full time basis for 14 consecutive days or less. His Disability will be subject to the same terms of the Policy as his prior claim and will be treated as a continuation of that Disability.

Any Disability which occurs after 14 consecutive days from the date the Covered Person's prior claim ended will be treated as a new claim. His new claim will be subject to all of the provisions, including the Elimination Period.

If he becomes entitled to benefits under any other Group Short Term Disability policy, he will not be eligible for payments under the Policy.

Recurrent Disability means: a Disability that is:

1. caused by a worsening in the Covered Person's condition; and
2. due to the same cause(s) as his prior Disability for which We made a payment.

Employee Outreach Services: We may provide Employee Outreach Services for a Covered Person who has a medical disability accompanied by psychosocial problems that may interfere with his recovery and return to work.

Employee Outreach Services will be provided at our discretion and may include, but are not limited to:

1. service provider referrals; and
2. identifying available community and state resources that may be helpful in the Covered Person's recovery and return to work.

Termination of Benefits: We will stop sending the Covered Person payments and his claim will end on the earliest of:

1. the date he is no longer Disabled according to the terms of the Policy;
2. the date he reaches the end of the Maximum Benefit Period;
3. the date he fails to provide proof of continuing Disability;
4. the date he is able to increase his Disability Earnings by increasing the number of hours he works or the number of duties he performs, but he chooses not to do so;
5. the date he refuses to be examined by a Physician, if such an exam is requested by Us;
6. the date he refuses to be interviewed by one of Our representatives;
7. the date he ceases to be under the Regular Care of a Physician;
8. the date he dies.

General Exclusions: We will not cover a Disability under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. intentionally self-inflicted Injuries;
3. active participation in a riot;
4. committing or attempting to commit a felony
5. an Occupational Sickness or Injury if the Schedule of Benefits indicates that benefits are issued on a non-occupational basis. However, We will cover Disabilities due to an

Occupational Sickness or Injury for partners or sole proprietors who cannot be covered by Workers' Compensation Law.

We will not make a payment for any period of time during which the Covered Person is incarcerated or under House Arrest. The Maximum Benefit Period will be reduced by the amount of time he is incarcerated or under House Arrest after completion of the Elimination Period.

Occupational Sickness or Injury means: an Injury arising out of, or in the course of, any work for wage or profit regardless of employer, or a Sickness covered, with respect to such work, by any Workers' Compensation Law, occupational disease Law or similar Law.

House Arrest means: any restriction placed on the Covered Person's movement outside of his home by a court of competent jurisdiction. Compliance with such restriction is regularly monitored using electronic or other means.

Claim Information:
Notice of Claim: Written notice of a claim must be given to Us at Our Home Office by the Covered Person within 30 days after the date his Disability begins. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature and extent of the Disability.

The Covered Person must notify Us immediately when he returns to work in any capacity.

Filing a Claim: The Covered Person and his employer must fill out their own section of the claim form and then give it to the Covered Person's attending Physician. The Physician should fill out his section of the form and send it directly to Us.

Proof of Claim: Written proof of claim must be filed within 90 days after the Covered Person's Elimination Period ends. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of claim must include:

1. the date the Covered Person's Disability began;
2. appropriate documentation of the Disabling disorder;
3. the extent of the Covered Person's Disability, including restrictions and limitations preventing him from being Actively at Work and performing his Regular Occupation;
4. the appropriate documentation of the Covered Person's earnings;
5. the name and address of any Hospital or Medical Facility where the Covered Person received Treatment;
6. the name and address of all Physicians providing Regular Care or specialty care.

We may request that the Covered Person send proof of continuing Disability, satisfactory to Us, indicating that he is under the Regular Care of a Physician. This proof, provided at the Covered Person's expense, must be received within 30 days of a request by Us.

In some cases, the Covered Person will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of his proof of claim, or proof of continuing Disability. We will deny a Covered Person's claim or stop sending him payments if the appropriate information is not submitted.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

Payment of Claim: Except as otherwise noted for specified additional benefits that may be included in the Policy, all benefits are payable to the Covered Person. If a benefit is payable to the Covered Person's estate, to a minor or to someone who is not competent to give a valid release, We have the right to pay up to $1,000 to any of the Covered Person's relatives whom We consider entitled. Any amount We pay in good faith releases Us from further liability, but only for the amount paid.

Overpayment of Claim: We have the right to recover any overpayments due to:

1. fraud;
2. any error We make in processing a claim; and
3. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's spouse if living, otherwise his children under the age of 25, or his estate.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than three years after the date of loss.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE
OPTIONAL BENEFITS
LUMP SUM SURVIVOR BENEFIT

When We receive proof that the Covered Person died, We will pay his spouse, if living, otherwise, his children under age 25 a lump sum benefit equal to 3 weeks of the Covered Person's weekly Gross Disability Payment but not to exceed $3,000.

The Lump Sum Survivor Benefit will be paid if, on the date of the Covered Person's death:

1. his Disability had continued for at least 15 consecutive days; and
2. he was receiving or was entitled to receive a Weekly Payment under the Policy.

If the Covered Person has no living spouse or children, payment will be made to his estate. However, We will first apply the survivor benefit to any overpayment which may exist on his claim.

The Covered Person may choose to receive his lump sum survivor benefit prior to his death if:

1. he has been diagnosed as having a life expectancy of less than 12 months; and
2. he is receiving a Weekly Payment under the Policy.

The Covered Person must notify Us in writing of his choice to exercise this option. Additionally, his Physician must certify in writing that he has a life expectancy of less than 12 months.

If the Covered Person elects to receive this benefit prior to his death, no lump sum survivor benefit will be payable upon his death.

United HealthCare Insurance Company
Notice of Privacy Policy and Practices

Purpose of this Notice
United HealthCare Insurance Company respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the personal information we receive. Our practices apply to current and former members.

Types of Personal Information We Collect
We collect a variety of personal information to administer a member's life or health coverage. Some of this information is provided by members in enrollment forms, surveys and correspondence (such as address, Social Security number, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions with our affiliates and members, employers, insurance agents, other insurers, and health care providers. We retain this information after a member's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal Information
We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide our products or services to members (for example, our claims processors and care coordinators). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal Information
We may share any of the personal information we collect (as described above) with our affiliates as permitted by law. We may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a member's authorized representative, health care providers, third party administrators, insurance agents and brokers, other insurers, consumer reporting agencies, and law enforcement or regulatory authorities. We may also disclose any of the personal information we collect (as described above) to companies that perform marketing services on our behalf or to other companies with whom we have joint marketing or disease management agreements. We do not disclose personal information to any other third parties without a member's request or authorization.

Individual Rights to Access and Correct Personal Information
We have procedures for a member to access the personal information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the member upon written request. Our goal is to keep our member information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal information we have about you is not accurate, please let us know by contacting our Compliance Officer at Unimerica Workplace Benefits, Mail Route MN010-W115, 6300 Olson Memorial Highway, Golden Valley, MN 55427.

Further Information
We may amend our privacy policy from time to time. In accordance with applicable law, we will send our current customers a Notice describing our privacy policy and practices at least once a year. It will also be available upon request. This Notice is provided on behalf of the following United HealthCare Insurance Company affiliates:

For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Eyecare of North Carolina, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

UnitedHealthcare®
Specialty Benefits℠

GROUP LONG TERM DISABILITY CERTIFICATE OF COVERAGE

FOR

ABC COMPANY

POLICY NUMBER: 123456

EFFECTIVE DATE: January 1, 2006

Any State

(11-05)

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United HealthCare Insurance Company

450 Columbus Boulevard

Hartford, Connecticut

(Home Office)

Policyholder: ABC Company

Effective Date of Policyholder: January 1, 2006

Policy Number: 123456

Covered Person: As on file with the Administrator

Certificate Number: As on file with the Administrator

Certificate Effective Date: As on file with the Administrator

We, United HealthCare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person eligible for insurance.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder, or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

It is signed at the Home Office of United HealthCare Insurance Company as of the Effective Date shown above.

Matthew Friedman

Secretary

President

Group Working Returns
Long Term Disability Insurance Policy
Non-Participating

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

SCHEDULE OF BENEFITS

Class of Employees
This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

All full-time Employees, excluding temporary and seasonal employees

Description of Class:

Employees are considered full-time if they customarily work: 30 hours per week

Employee Waiting Period:

An Employee is eligible for insurance on the later of the following dates:

1. The Group Policy's Effective Date, January 1, 2006
2. The first day of the month following the date the Employee completes 30 days of continuous employment with the Policyholder.

If the Covered Person's employment ends and the same employer rehires him within one year, We will apply his previous employment in an eligible class toward completing the Waiting Period.

Covered Person Insurance:

Long Term Disability Benefit:

Benefit Percent: 60% of the Covered Person's Pre-Disability Monthly Earnings. The Covered Person's benefit may be reduced by Other Income Benefits and Disability Earnings. Some Disabilities may not be insured under the Policy.

Pre-Disability Monthly Earnings Definition:
The average monthly earnings received from the Covered Person's employer for the 12-month period ending just prior to the date of Disability. Pre-Disability Monthly Earnings include commissions, averaged over the lesser of the most recent 24-month period or the Covered Person's period of employment. It does not include bonuses, overtime pay, and other extra compensation.

Maximum Monthly Benefit: $6,000

Minimum Monthly Benefit: Greater of $100 or 10% of Gross Disability Payment

Elimination Period: 180 days - Benefits begin the day after completion of the Elimination Period.

Accumulation of Elimination Period: 30 days

Maximum Benefit Period:
Reducing Benefit Duration reflecting Social Security Normal Retirement Age.

Age at Disability	Maximum Benefit Period
	Greater of SSNRA * or
Less than age 60	To age 65
Age 60	60 Months
Age 61	48 Months
Age 62	42 Months
Age 63	36 Months
Age 64	30 Months
Age 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
69 and over	12 Months

SCHEDULE OF BENEFITS (continued)

*SSNRA means the Social Security Normal Retirement Age as figured by the 1983 amendment or any later amendment to the Social Security Act.

Premium contributions are waived while the Covered Person is receiving Long Term Disability payments.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave.)

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Dependent: Includes

1. a legal Spouse including a Domestic Partner; and
2. any unmarried Child.

A Child is:

1. less than 19 years of age; or
2. an Eligible Student;
   a. who is not married;
   b. who is not in the armed forces of any country;
   c. who is not insured under the Policy as a Covered Person;
   d. who is less than 25 years of age;
   e. who attends an accredited post-secondary school (other than a correspondence school) on a full-time basis as defined by the post-secondary school; and
   f. is enrolled in the next scheduled term.

   or

3. physically or mentally Disabled.

The term "Child" includes a natural child, legally adopted child, stepchild, foster child, or any child who lives with the Covered Person in a regular parent-child relationship, provided the Covered Person claims such Child as a Dependent on the Covered Person's most recent federal income tax return.

Employee: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of the Policyholder will be considered an Employee unless he meets the above conditions.

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: A bodily Injury resulting directly from an accident and independently of all other causes.

Physician: A practitioner of the healing arts who is:

1. duly licensed in the state in which the Treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's spouse, children, parents, parents-in-law, or siblings.

Regular Care: The Covered Person personally visits a Physician as often as is medically required to effectively manage and treat his disabling condition(s), according to generally accepted medical standards. The Covered Person is receiving appropriate Treatment and care, according to generally accepted medical standards, by a Physician whose specialty or experience is appropriate for the disabling condition(s).

Sickness: An illness, disease, pregnancy or complication of pregnancy.

Treatment: consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: United HealthCare Insurance Company.

CERTIFICATE GENERAL PROVISIONS

Discretionary Authority: When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's or Dependent's eligibility, if applicable, for benefits and to interpret the terms and provisions of the Policy. This provision applies, however, only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Misstatement of Age: If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at Our Home Office. A Grace Period of 31 days from the Premium Due Date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will remain in effect provided the premium is paid before the end of the Grace Period. Payment of Premium for a period before it is due will not guarantee that the insurance will remain in effect for that period.

CERTIFICATE GENERAL PROVISIONS (continued)

Premium Rate Change: We have the right to change premium rates as of any Premium Due Date but not more than once in any 12-month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more;
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Workers' Compensation laws.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
    a. the date the Employee is eligible for insurance, regardless of when he applies; or
    b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

Effective Date of Change in Amount of Insurance: If there is an increase in the amount of the Covered Person's insurance, the increase will take effect on:

1. the first day of the month on or next following the date of the increase, if the Covered Person is Actively at Work on the date of increase;
2. the date the Covered Person returns to Active Work if the Covered Person is not Actively at Work on the first day of the month on or next following the date of the increase;
3. the first day of the month on or next following the date of the increase, if the first day of the month is a non-working day and the Covered Person was Actively at Work on his last scheduled working day before the non-working day;
4. the date of the increase if the Covered Person is on an approved layoff or leave of absence, for reasons other than a Sickness or Injury.

If evidence of insurability is required, the increase will take effect on the later of the dates indicated above or the date We approve his application.

A decrease in the amount of the Covered Person's insurance will take effect on the date of the decrease.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his employer's policy on Family and Medical Leaves of Absence.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his employer.

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his employer just prior to the date his Leave of Absence started to determine Our payments to him.

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date he ceases to be Actively at Work. If active work ceases the Policyholder may deem the Covered Person's employment continued during a temporary layoff or approved leave of absence. In such case, insurance will not continue beyond the end of the month following the month in which the layoff or leave began.
6. the date he is no longer Actively at Work due to a labor dispute, including but limited to strike, work slow down or lock out.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON

The Covered Person is Disabled or has a Disability when We determine that:

1. he is not Actively at Work and is unable to perform some or all of the Material and Substantial Duties of his Regular Occupation due to his Sickness or Injury; and
2. he has a 20% or more loss in Indexed Pre-Disability Monthly Earnings due solely to the same Sickness or Injury, and
3. he is under the Regular Care of a Physician.

After 24 months of payments, the Covered Person is Disabled when We determine that due to the same Sickness or Injury, he is unable to perform some or all of the material and substantial duties of any Gainful Occupation for which he is reasonably fitted by education, training or experience and he continues to suffer a 20% or more loss in his Indexed Pre-Disability Monthly Earnings due solely to the Sickness or Injury.

Material and Substantial Duties: duties that

1. are normally required for the performance of the Covered Person's Regular Occupation; and
2. cannot be reasonably omitted or modified.

Regular Occupation means: the occupation which the Covered Person is routinely performing when his Disability occurs. We will look at the Covered Person's occupation as it is normally performed in the national economy instead of how the work tasks are performed for a specific employer or at a specific location.

Gainful Occupation means: an occupation that can be expected to provide the Covered Person with an income at least equal to his Gross Disability Payment within 12 months of his return to work, considering:

1. his past training, as well as training he could receive;
2. his education and experience; and
3. his physical and mental capacity.

Gainful Occupation will be determined with the assistance of a licensed vocational or rehabilitation specialist.

Disability must begin while the Covered Person is insured under the Policy.

The loss of a professional or occupational license or certification does not, in itself, mean the Covered Person is Disabled. Additionally, economic factors, such as recession, job obsolescence, pay-cuts and job sharing will not be considered in determining whether the Covered Person meets the definition of Disability/Disabled.

We require the Covered Person to be under the Regular Care of a Physician for the Sickness or Injury causing his disability in order to be eligible to receive payments from Us.

We may require the Covered Person to be examined by Physicians, other medical practitioners or vocational experts of Our choice. We will pay for these examinations. We can require examinations as often as it is reasonable to do so. We may also require the Covered Person to be interviewed by an authorized representative of Ours. Refusal to be examined or interviewed may result in denial or termination of his claim.

Transplant Benefit: If, while insured under the Policy, the Covered Person donates an organ for an Organ Transplant Procedure, and as a result he becomes Disabled, We will consider him to be Disabled as a result of Sickness and his Elimination Period will be waived. Disability resulting from an Organ Transplant Procedure will have a limited pay period of 12 months. This benefit will be payable only once in the Covered Person's lifetime. Benefit payments will be subject to all of

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

the provisions contained in the Policy, except for those that are in conflict with the provisions of this Transplant Benefit.

Organ Transplant Procedure means: the Covered Person donates any of the following for transplantation into another person: kidney, liver, lung, skin or bone marrow.

Calculating the Monthly Payment:
The Benefit Percent and Maximum Monthly Benefit are shown in the Schedule of Benefits.

If the Covered Person is Disabled and not working, or working and earning less than 20% of his Pre-Disability Monthly Earnings:

Calculate the Covered Person's Monthly Payment as follows:

1. Multiply the Covered Person's Pre-Disability Monthly Earnings by the Benefit Percent.
2. Compare the result in Step 1 with the Maximum Monthly Benefit.
3. The lesser of these two amounts is the Covered Person's monthly Gross Disability Payment.
4. Subtract from his monthly Gross Disability Payment all Other Income Benefit amounts that he receives or is eligible to receive. The result is the Covered Person's Monthly Payment.

In no event will the Covered Person's Monthly Payment exceed the Maximum Monthly Benefit.

If the Covered Person is Disabled and working, earning between 20% and 80% of his Indexed Pre-Disability Monthly Earnings:

Calculate the Covered Person's Gross Disability Payment as follows:

1. Multiply his Pre-Disability Monthly Earnings by the Benefit Percent.
2. Compare the result in Step 1 with the Maximum Monthly Benefit.
3. The lesser of these two amounts is the Covered Person's Gross Disability Payment, which is used in the benefit calculation below.

When the Covered Person first returns to work during a period of disability, the Work Incentive Benefit establishes that, for 12 months, his Monthly Payment, as determined above, will not be reduced as long as Payment does not exceed 100% of his Indexed Pre-Disability Monthly Earnings.

During the period of time that the Work Incentive Benefit applies:

1. Add the Covered Person's monthly Disability Earnings to his Gross Disability Payment, as calculated above.
2. Compare the result in Step 1 to his Indexed Pre-Disability Monthly Earnings.
3. If the result from Step 2 is less than or equal to 100% of the Covered Person's Indexed Pre-Disability Monthly Earnings, We will not further reduce his Monthly Payment, as calculated above.
4. If the result in Step 2 is greater than 100% of the Covered Person's Indexed Pre-Disability Monthly Earnings, We will subtract the amount over 100% from his Monthly Payment, as calculated above. This is the amount We will pay the Covered Person each month.

After the period of time that the Work Incentive Benefit applies:

1. Subtract the Covered Person's Disability Earnings from his Indexed Pre-Disability Monthly Earnings.
2. Divide the result in Step 1 by his Indexed Pre-Disability Monthly Earnings. This is his percentage of lost earnings.
3. Multiply the Covered Person's Monthly Payment, as calculated above, by the answer in Step 2. This is the amount We will pay the Covered Person each month.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

After the Elimination Period, if the Covered Person is Disabled for only part of a month, We will send him 1/30th of his Monthly Payment for each day of Disability.

Gross Disability Payment means: the payment amount before We subtract Other Income Benefits and Disability Earnings.

Elimination Period means: the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability. If the Covered Person returns to work for a period of time not to exceed the Accumulation of Elimination Period and cannot continue, he will not have to begin a new Elimination Period. However, We will count only those days he is Disabled toward satisfying the Elimination Period. The Elimination Period and the Accumulation of Elimination Period are shown in the Schedule of Benefits.

Disability Earnings mean: the earnings, which the Covered Person receives while Disabled, and working plus the earnings he could receive if he was working to his Maximum Capacity.

Maximum Capacity means: the greatest extent of work the Covered Person is able to do, given his limitations, restrictions, and physical and mental capacity, in an occupation that is available in his location and for which he is reasonably fitted by education, training, and experience.

Indexed Pre-Disability Monthly Earnings: The Covered Person's Pre-Disability Monthly Earnings adjusted on each anniversary of benefit payments by the lesser of 5% or the current annual percentage increase in the Consumer Price Index (CPI-W). The Covered Person's Indexed Pre-Disability Monthly Earnings may increase or remain the same, but will never decrease. This manner of indexing is only used to determine the Covered Person's percentage of lost earnings while he is Disabled and working and in the determination of Gainful Occupation. Consumer Price Index (CPI-W) means: the index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Receipt of Disability Payments: The Covered Person will begin to receive payments when We approve his claim, provided the Elimination Period has been met and he is Disabled. We will send him a payment each month for any period for which We are liable. If he is Disabled and working, proof of Disability Earnings will be required before benefits are paid.

Disability During a Covered Layoff or Leave of Absence: If the Covered Person becomes Disabled while he is on a covered Layoff or Leave of Absence, We will calculate his benefit using his Pre-Disability Monthly Earnings from his employer in effect just prior to the date his absence begins.

Fluctuation of Disability Earnings: If the Covered Person's Disability Earnings fluctuate, We may average his Disability Earnings over the most recent 3 months to determine if his claim should continue subject to all other terms and conditions in the Policy.

If We average his Disability Earnings, We will not terminate his claim unless the average of his Disability Earnings from the last 3 months exceeds 80% of his Indexed Pre-Disability Monthly Earnings.

We will not pay the Covered Person for any month during which Disability Earnings exceed the amount allowable under the Policy.

Other Income Benefits: We will subtract from the Covered Person's Gross Disability Payment the following Other Income Benefits:

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

1. any benefits and awards he receives or is eligible to receive under:
   a. Workers' Compensation Law;
   b. occupational disease Law; or
   c. any other similar Act or Law.

2. any Disability income benefits he receives or is eligible to receive under:
   a. any compulsory benefit Act or Law;
   b. any other group insurance policy with the employer or with an association;
   c. any other group insurance policy with another employer under which he becomes insured while he is Disabled under the Policy; or
   d. any governmental retirement system as the result of his job with his employer.

3. any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, the Jones Act, and any other similar plan or Act. Benefits include:
   a. Disability benefits he is eligible to receive and any disability benefits his spouse or his children receive or are eligible to receive as a result of his Disability.
   b. retirement benefits he receives and any retirement benefits his spouse or his children receive as a result of his receipt of retirement benefits.

   If the Covered Person's Disability begins after his 70th birthday, and he was receiving Social Security retirement benefits before his Disability began, then We will not reduce Our payments to him by these retirement benefits.

   Pension Plan means: a plan that provides retirement benefits and which is not wholly funded by Employee contributions. The term does not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity plan (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.

4. any benefits he receives from the employer's sick leave or salary continuation plan.

5. any benefits from the employer's retirement plan , the Public Employees Retirement System and the State Teachers Retirement System he:
   a. receives as disability benefits;
   b. voluntarily chooses to receive as retirement benefits; or
   c. receives as retirement benefits once he reaches the greater of age 62 or normal retirement age, as defined in his employer's Retirement Plan.

   Regardless of how the retirement funds from the plan are distributed, for the purposes of determining Our payment to the Covered Person, We consider Employee and employer contributions to be distributed at the same time throughout the Covered Person's lifetime.

   We will not reduce payments the Covered Person receives from Us for his contributions to the employer's retirement plan, or for amounts he rolls over or transfers to an eligible Retirement Plan.

   Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

   Retirement benefits under a retirement plan are benefits that are paid based on the Covered Person's employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit.

   Eligible retirement plan is defined in Section 402 of the Internal Revenue Code of 1986

and includes future amendments to Section 402 affecting the definition.

6. any benefits for loss of time or lost wages he receives from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.

7. any amount he receives under any unemployment compensation Law.

8. any amounts he receives from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

If the Covered Person receives any of the Other Income Benefits in a lump sum payment, We will pro-rate the lump sum on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis to the end of the Covered Person's Maximum Benefit Period.

Other Income Benefits must be payable as a result of the same Disability for which the Covered Person is receiving a payment from Us, except for retirement benefits.

We will NOT subtract from the Covered Person's Gross Disability Payment any amounts he receives from the following sources:

1. 401(k) plans
2. profit sharing plans
3. thrift plans
4. tax sheltered annuities
5. stock ownership plans
6. non-qualified plans of deferred compensation
7. Pension plans for partners
8. military pension and military disability income plans
9. credit disability insurance
10. franchise disability income plans
11. a retirement plan from another employer
12. Individual Retirement Accounts (IRA)
13. individual disability income plans

Affect of Other Income Benefits on Payment: If subtracting Other Income Benefits results in a zero benefit, We will pay the Covered Person the Minimum Monthly Benefit shown in the Schedule of Benefits. The Minimum Monthly Benefit, however, may be applied toward an outstanding overpayment.

Cost of Living Increases: After the first deduction for each of the Other Income Benefits, We will not further reduce the amount of the Covered Person's Monthly Payment under the Policy due to cost of living increases he receives from any of the sources described in the "Other Income Benefits" section.

Estimating Amounts of Other Income Benefits: We have the right to estimate the amount of benefits the Covered Person may be eligible to receive under the "Other Income Benefits" section. We can reduce Our payments to him by the estimated amount if:

1. he has not been awarded but has not been denied such benefits; or
2. he has been denied such benefits and the denial is being appealed; or
3. he is reapplying for such benefits.

We will NOT reduce Our payments to the Covered Person by the estimated amount if:

1. he applies or reapplies for the benefits and appeals his denial through all of the

administrative levels We believe are necessary;
2. he signs Our reimbursement agreement form stating that he promises to pay Us any overpayment caused by an award.

If We reduce Our payments to the Covered Person by an estimated amount:
1. We will adjust Our payment to him when he provides proof of the amount awarded; or
2. We will issue a lump sum refund of the estimated amount if he was denied benefits and has completed all appeals (or reapplications) We believe are necessary.

Termination of Benefits: We will stop sending the Covered Person payments and his claim will end on the earliest of:
1. the date he is no longer Disabled according to the terms of the Policy;
2. the date he reaches the end of the Maximum Benefit Period;
3. the date he fails to provide proof of continuing Disability;
4. the date his Disability Earnings exceed the amount allowable under the Policy;
5. the date he is able to increase his Disability Earnings by increasing the number of hours he works or the number of duties he performs but he chooses not to do so;
6. the date he refuses to be examined by a Physician, if such an exam is requested by Us;
7. the date he refuses to be interviewed by one of Our representatives;
8. the date he ceases to be under the Regular Care of a Physician;
9. the date he dies.

If the Covered Person is a citizen of the United States and is receiving Treatment outside of the United States, We may require him to return to the United States for Treatment. Failure to do so when requested may result in termination of benefits.

Limitations:
Mental Illness and Substance Abuse Limitation
Disabilities due to Mental Illness or Substance Abuse have a limited pay period of 24 months per disability.

We will continue to send the Covered Person payments beyond the limited pay period if he is confined to a Hospital or Medical Facility. If he is still Disabled when he is discharged, We will send him payments for a recovery period of up to 90 days. If he becomes re-confined at any time during the recovery period and remains confined for at least 14 days in a row, We will send payments during that additional confinement and for one additional recovery period up to 90 more days.

In no case will benefits be paid beyond the Maximum Benefit Period.

Mental Illness means: any Sickness, disease or disorder, which is:

1. listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
2. usually treated by a mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental Illness includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include, but are not limited to:
1. bipolar disorder;
2. depression and depressive disorders;
3. psychoses;

4. mood disorders;
5. manic-depressive illness;
6. anxiety disorders;
7. stress disorders including post-traumatic stress disorders;
8. somatoform disorders;
9. factitious disorders;
10. eating disorders;
11. adjustment disorders; and
12. personality disorders.

For purposes of the Policy, Mental Illness does not include coma (unless a consequence of Substance Abuse), mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis.

Substance Abuse means: alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician.

General Exclusions: We will not cover a Disability under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. intentionally self-inflicted Injuries;
3. active participation in a riot; or
4. committing or attempting to commit a felony.

We will not make a payment for any period of time during which the Covered Person is incarcerated or under House Arrest. The Maximum Benefit Period will be reduced by the amount of time he is incarcerated or under House Arrest after completion of the Elimination Period.

Pre-Existing Condition Exclusion: 3/12
We will not cover any Disability that begins during the first 12 months after the Covered Person's Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

Pre-Existing Condition means: any Sickness or Injury including Mental Illness, Substance Abuse for which the Covered Person, within 3 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which an ordinarily prudent person would have sought Treatment.

Continuity of Insurance Upon Transfer of Insurance Carriers: In order to prevent loss of insurance for a Covered Person because of a transfer of insurance carriers, We will provide insurance for certain Employees as follows:

Employees who are not Actively at Work due to Sickness or Injury:

We will insure the Employee under this Policy if the prior group insurance policy insured him and the cost of his insurance under the prior group insurance policy was paid.

Our payments to the Employee will be limited to the lesser of the Monthly Payment under the Policy or the monthly benefit the prior group insurance policy would have paid him, had that policy stayed in effect. Our payments will be reduced by any amount the prior group insurance policy is responsible for paying.

Employees who are Disabled due to a Pre-Existing Condition

If the Employee was insured by the prior group insurance policy immediately prior to becoming

eligible for insurance under this Policy, he is Actively at Work and he is insured under this Policy, then he may be eligible for payments under this Policy if his Disability is due to a Pre-Existing Condition.

In order to receive payments from Us, the Employee must satisfy the Pre-Existing Condition Exclusion test of:

1. this Policy; or
2. the prior group insurance policy, had that policy stayed in effect.

We will give credit toward continuous time insured under both policies. We will determine Our payments using the provisions of this Policy, but the Employee's Monthly Payment will not be more than the maximum monthly payment of the prior group insurance policy.

The Employee's Monthly Payment will end on the earlier of the following:

1. the end of the Maximum Benefit Period;
2. the date benefits would have ended under the prior group insurance policy, if the policy had stayed in effect.

If the Employee cannot satisfy the Pre-Existing Condition Exclusion test of either policy, then he will not be eligible for a Monthly Payment.

Recurrent Disability: If the Covered Person's current Disability is related or due to the same causes(s) as his prior Disability for which We made a payment, We will treat his current Disability as part of his prior claim and he will not have to complete another Elimination Period if he returns to Active Work for his employer on a full time basis for 6 consecutive months or less. His Disability will be subject to all of the provisions as his prior claim and will be treated as a continuation of that Disability.

Any Disability which occurs after 6 consecutive months from the date the Covered Person's prior claim ended will be treated as a new claim. His new claim will be subject to all of the provisions, including the Elimination Period.

If the Covered Person becomes entitled to benefits under any other Group Long Term Disability policy, he will not be eligible for payments under the Policy.

Recurrent Disability means: a Disability that is:

1. caused by a worsening in the Covered Person's condition; and
2. due to the same cause(s) as his prior Disability for which We made a payment.

Lump Sum Survivor Benefit: When We receive proof that the Covered Person died, We will pay his spouse, if living, otherwise, his children under age 25, a lump sum benefit equal to 3 months of the Covered Person's monthly Gross Disability Payment if, on the date of the Covered Person's death:

1. his Disability had continued for 180 or more consecutive days; and
2. he was receiving or was entitled to receive a Monthly Payment under the Policy.

If the Covered Person has no living spouse or children, payment will be made to his estate. However, We will first apply the survivor benefit to any overpayment which may exist on the Covered Person's claim.

Workplace Modification Benefit: A workplace modification benefit may be payable to the Covered Person's employer if a change is made to the work environment or the way a job is performed to allow the Covered Person to be Actively at Work and to perform the Material and Substantial Duties of his Regular Occupation, or any Gainful Occupation.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

To qualify for a benefit:

1. the Covered Person must be Disabled under the terms of the Policy;
2. the employer must agree to make the necessary modifications so that the Covered Person can return to work; and
3. any proposed modifications to the work place must be in writing and approved by Us prior to implementation.
4. In considering any proposed modifications, We have the right to have the Covered Person evaluated by a Physician or other health care professional, or a vocational rehabilitation specialist of Our choice.

When the above qualifications are met, the Covered Person's employer will be reimbursed for the cost of the modification up to a maximum amount for the Workplace Modification Benefit. This benefit is available to the Covered Person on a one-time-only basis, at Our discretion, and will be paid in addition to any other Disability benefits for which the Covered Person qualifies. The Workplace Modification Benefit maximum is $5,000.

Rehabilitation Services: A rehabilitation program is available to assist the Covered Person in his return to work. Participation in this program is voluntary on his part and will be offered at Our discretion.

Our vocational rehabilitation specialists will review the Covered Person's file to determine if rehabilitation services might help him return to a Gainful Occupation. Once the review is completed, We may offer and pay for a return to work program. We will work with the Covered Person's Physician and other appropriate specialists to develop a plan that best suits the Covered Person's needs.

The return to work program may include, but is not limited to, the following services:

1. coordination with the Covered Person's employer to assist him in his return to work;
2. evaluation of adaptive equipment to allow the Covered Person to work;
3. vocational evaluation to determine how his Disability may impact his employment options;
4. job placement services;
5. resume preparation;
6. job seeking skills training;
7. retraining for a new occupation; or
8. assistance with relocation that may be part of an approved return to work program.

We reserve the right to make the final decision concerning the Covered Person's eligibility to take part in a rehabilitation program and the amount of any services he will be provided.

During the Covered Person's participation in an approved rehabilitation program, his Gross Disability Payment will be increased by 5% for Rehabilitation Services.

In addition, We will make monthly payments to the Covered Person for 3 months following the date his Disability ends if We determine he is no longer Disabled while:

1. he is participating in Our rehabilitation program; and
2. he is not able to find employment.

Employee Outreach Services: We may provide Employee Outreach Services for a Covered Person who has a medical disability accompanied by psychosocial problems that may interfere with his recovery and return to work.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

Employee Outreach Services will be provided at our discretion and may include, but are not limited to:

1. service provider referrals; and
2. identifying available community and state resources that may be helpful in the Covered Person's recovery and return to work.

Social Security Assistance: If the Covered Person is receiving a payment from Us, We can provide advice to him regarding his Social Security Disability benefits claim and assist him with his application or appeal.

Receiving Social Security Disability benefits may enable:

1. him to receive Medicare after 24 months of disability payments;
2. him to protect his retirement benefits; and
3. his family to be eligible for Social Security benefits.

We can assist the Covered Person in obtaining Social Security disability benefits by:

1. helping him find appropriate legal representation or other assistance;
2. obtaining medical and vocational evidence; and
3. reimbursing pre-approved case management expenses.

Claim Information:

Notice of Claim: Written notice of a claim must be given to Us at Our Home Office by the Covered Person within 30 days after the date his Disability begins. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature and extent of the Disability.

The Covered Person must notify Us immediately when he returns to work in any capacity.

Filing a Claim: The Covered Person and his employer must fill out their own section of the claim form and then give it to the Covered Person's attending Physician. The Physician should fill out his section of the form and send it directly to Us.

Proof of Claim: Written proof of claim must be filed within 90 days after the Covered Person's Elimination Period ends. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of claim must include:

1. the date the Covered Person's Disability began;
2. appropriate documentation of the Disabling disorder;
3. the extent of the Covered Person's Disability, including restrictions and limitations preventing him from being Actively at Work;
4. the appropriate documentation of the Covered Person's earnings;
5. the name and address of any Hospital or Medical Facility where the Covered Person received Treatment;
6. the name and address of all Physicians providing Regular Care or specialty care.

We may request that the Covered Person send proof of continuing Disability, satisfactory to Us, indicating that he is under the Regular Care of a Physician. This proof, provided at the Covered Person's expense, must be received within 30 days of a request by Us.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

In some cases, the Covered Person will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of his proof of claim, or proof of continuing Disability. We will deny a Covered Person's claim or stop sending him payments if the appropriate information is not submitted.

Payment of Claim: Except as otherwise noted for specified additional benefits that may be included in the Policy, all benefits are payable to the Covered Person. If a benefit is payable to the Covered Person's estate, to a minor or to someone who is not competent to give a valid release, We have the right to pay up to $1,000 to any of the Covered Person's relatives whom We consider entitled. Any amount We pay in good faith releases Us from further liability, but only for the amount paid.

Overpayment of Claim: We have the right to recover any overpayments due to:

1. fraud;
2. any error We make in processing a claim; and
3. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's spouse if living, otherwise his child under the age 25, or his estate.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than three years after the date of loss.

WORKING RETURNS LONG TERM DISABILITY INSURANCE
OPTIONAL BENEFITS PORTABILITY

If the Covered Person's insurance under the Policy ends because his employment with the employer ends, then he may choose to continue his Group Long Term Disability Insurance without providing evidence of insurability.

The Covered Person must be insured under the Policy for at least 12 months prior to the date his employment ends.

The Covered Person is not eligible to continue his insurance if:

1. he is Disabled under the terms of the Policy; or
2. he has recovered from a Disability under the terms of the Policy, but did not choose to return to work with the employer; or
3. he failed to pay premium for the cost of his insurance; or
4. he is on an approved Leave of Absence; or
5. he retires; or
6. he is or becomes insured under another group long term disability policy; or
7. the Policy terminates.

Retire means: for purposes of this Portability benefit, the Covered Person has concluded his working career on a full-time basis and:

1. he is receiving payments from a governmental retirement plan or any employer;
2. he is receiving Social Security Retirement benefits; or
3. he is no longer seeking active, full-time employment.

To apply for Portability insurance, within 31 days of the date the Covered Person's insurance ends he must:

1. submit a written application to Us; and
2. pay the first month's premium.

If the above conditions are met, such insurance will:

1. be issued without evidence of insurability; and
2. continue in effect for 12 months provided the Covered Person continues to pay the cost of his insurance.

The Portability insurance will end on the earliest of:

1. the date the Covered Person fails to pay the required premium;
2. the date he retires;
3. the date he becomes insured under any other group long term disability policy;
4. the date the Policy terminates; or
5. the date following 12 months of Portability insurance.

Employees rehired after porting insurance must either lapse that insurance or provide evidence of insurability.

United HealthCare Insurance Company
Notice of Privacy Policy and Practices

Purpose of this Notice
United HealthCare Insurance Company respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the personal information we receive. Our practices apply to current and former members.

Types of Personal Information We Collect
We collect a variety of personal information to administer a member's life or health coverage. Some of this information is provided by members in enrollment forms, surveys and correspondence (such as address, Social Security number, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions with our affiliates and members, employers, insurance agents, other insurers, and health care providers. We retain this information after a member's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal Information
We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide our products or services to members (for example, our claims processors and care coordinators). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal Information
We may share any of the personal information we collect (as described above) with our affiliates as permitted by law. We may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a member's authorized representative, health care providers, third party administrators, insurance agents and brokers, other insurers, consumer reporting agencies, and law enforcement or regulatory authorities. We may also disclose any of the personal information we collect (as described above) to companies that perform marketing services on our behalf or to other companies with whom we have joint marketing or disease management agreements. We do not disclose personal information to any other third parties without a member's request or authorization.

Individual Rights to Access and Correct Personal Information
We have procedures for a member to access the personal information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the member upon written request. Our goal is to keep our member information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal information we have about you is not accurate, please let us know by contacting our Compliance Officer at Unimerica Workplace Benefits, Mail Route MN010-W115, 6300 Olson Memorial Highway, Golden Valley, MN 55427.

Further Information
We may amend our privacy policy from time to time. In accordance with applicable law, we will send our current customers a Notice describing our privacy policy and practices at least once a year. It will also be available upon request. This Notice is provided on behalf of the following United HealthCare Insurance Company affiliates:

For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Eyecare of North Carolina, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

ENROLLMENT FORM

Group Life and Disability Insurance products provided by United HealthCare Insurance Company. Dental Insurance products provided by United HealthCare Insurance Company

Use this form to apply or make changes to the coverages listed below.
Late applicants are subject to Evidence of Insurability.

A. EMPLOYEE INFORMATION

☐ Enroll ☐ Cancel ☐ Address Change ☐ Name Change ☐ Other   Date

Last Name	First Name	M.I.	Social Security Number	Gender ☐ M ☐ F	Date of Birth

Street Address	Apt No.	City	State	Zip Code	☐ Single ☐ Married

Home Phone ( )	Work Phone ( )	Annual Salary

Employer or Group Name	Division/Location	Subgroup Code	Job Title

B. PRODUCT SELECTION - Application for (check all that apply):

Life Insurance
- ☐ Basic Life Insurance
- ☐ Accidental Death and Dismemberment
- ☐ Dependent Spouse Insurance $ ____________ amount
- ☐ Dependent Child(ren) Insurance $ ____________ amount
- ☐ Supplemental Life $ ____________ amount
- ☐ Supplemental AD&D $ ____________ amount

(see Benefit Summary for amounts)

Beneficiary Designation:
Beneficiary's Full Name

Relationship to Employee

Disability Insurance
- ☐ Short Term Disability (STD)

  $ ____________ amount
- ☐ Long Term Disability (LTD)

  $ ____________ amount

(see Benefit Summary for information)

Dental Plan
- ☐ Unit Dental Options PPO Plan
- ☐ Unimerica Dental Managed Indemnity
- ☐ Waive

Indicate the coverage level
- ☐ Single
- ☐ Single + Spouse
- ☐ Single + Child(ren)
- ☐ Family

C. INFORMATION FOR DEPENDENT COVERAGE (List all family members to be covered)

Last name	First Name	M.I.	Date of Birth	Relationship	If child is over age 19, please indicate status and/or school	Gender	Check one
					☐ Handicapped ☐ Student at	☐M ☐F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
					☐ Handicapped ☐ Student at	☐M ☐F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
					☐ Handicapped ☐ Student at	☐M ☐F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
					☐ Handicapped ☐ Student at	☐M ☐F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
					☐ Handicapped ☐ Student at	☐M ☐F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
					☐ Handicapped ☐ Student at	☐M ☐F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change

D. SIGNATURE (This form must be signed)

I understand that by signing this form that I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

X ______________________________________ ______________
Signature of Employee   Date

E. EMPLOYER USE ONLY

☐ Initial enrollment following Date of Hire ☐ Late Applicant	Employee Hire Date (mm/dd/yyyy)	Signed for Employer by	Group Number

UnitedHealthcare® Specialty Benefits®

STATE OF NEBRASKA SUBCONTRACTOR LIST

RFP 5956 Z1

This section has been redacted from the proposal. The State of Nebraska Subcontractor List can be found in the separately packaged envelope marked "Proprietary Information."

UnitedHealthcare Insurance Company

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2017 and 2016,
Supplemental Schedules as of and
for the Year Ended December 31, 2017,
Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE INSURANCE COMPANY

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INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450

We have audited the accompanying statutory basis financial statements of UnitedHealthcare Insurance Company (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2017 and 2016, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements.

Management's Responsibility for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Connecticut Insurance Department. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the statutory basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory basis financial statements. The procedures selected depend on the auditor's judgment including the assessment of the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the statutory basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of UnitedHealthcare Insurance Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Connecticut Insurance Department described in Note 1 to the statutory basis financial statements.

Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by UnitedHealthcare Insurance Company using accounting practices prescribed or permitted by the Connecticut Insurance Department, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Connecticut Insurance Department. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2017 audit was conducted for the purpose of forming an opinion on the 2017 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories, the supplemental summary investment schedule, and the supplemental schedule of selected financial data, as of and for the year ended December 31, 2017, are presented for purposes of additional analysis and are not a required part of the 2017 statutory basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2017 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2017 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the audit committee and the management of UnitedHealthcare Insurance Company and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

May 8, 2018

UNITEDHEALTHCARE INSURANCE COMPANY

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2017 AND 2016

	2017	2016
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 8,048,935,578	$ 6,980,989,589
Preferred stocks	15,482,258	14,952,718
Common stocks	2,548,747,317	2,266,510,207
Properties occupied by the Company	291,612,782	282,107,409
Cash overdrafts of ($80,519,432) and ($170,229,223), cash equivalents of $840,845,265 and $57,545,515, and short-term investments of $1,899,064,464 and $1,835,034,987 in 2017 and 2016, respectively	2,659,390,297	1,722,351,279
Other invested assets	211,014,900	160,737,401
Receivables for securities	22,099,551	5,425,847
Total cash and invested assets	13,797,282,683	11,433,074,450
OTHER ASSETS:		
Investment income due and accrued	56,480,317	49,116,966
Premiums and considerations	2,464,215,104	2,166,553,124
Reinsurance	601,313,876	1,046,755,322
Amounts receivable relating to uninsured plans	295,109,005	592,249,848
Current federal income tax recoverable	-	157,896,371
Net deferred tax asset	278,400,978	458,843,870
Health care and other amounts receivable	1,950,141,545	1,867,167,248
Other assets	174,598,843	150,989,815
Total other assets	5,820,259,668	6,489,572,564
TOTAL ADMITTED ASSETS	$ 19,617,542,351	$ 17,922,647,014
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Aggregate reserves for life and accident and health contracts	$ 1,464,856,944	$ 1,362,750,168
Liability for deposit-type contracts	180,886,671	190,032,666
Contract claims	5,243,287,677	4,414,080,911
Premiums for life and accident and health contracts received in advance	402,035,624	361,724,808
Provision for experience rating refunds	2,195,621,551	2,266,803,025
Other amounts payable on reinsurance	563,516,576	1,027,749,306
Interest maintenance reserve	87,877,538	110,444,832
General expenses due or accrued	157,931,168	144,346,516
Taxes, licenses, and fees due or accrued, excluding federal income taxes	378,375,877	839,123,968
Current federal income taxes	133,220,235	-
Remittances and items not allocated	179,773,897	277,830,634
Asset valuation reserve	479,703,019	372,209,589
Payable to parent, subsidiaries, and affiliates, net	848,382,660	718,785,636
Liability for amounts held under uninsured plans	490,336,611	174,778,697
Funds held under coinsurance	186,019,707	166,040,911
Payable for securities	44,208,603	35,291,689
Other liabilities	226,297,429	210,206,928
Total liabilities	13,262,331,787	12,672,200,284
CAPITAL AND SURPLUS:		
Common capital stock, $6,000 par value—1,000 shares authorized; 500 shares issued and outstanding	3,000,000	3,000,000
Gross paid-in and contributed surplus	308,595,764	128,095,764
Section 9010 ACA subsequent fee year assessment	807,056,895	-
Unassigned surplus	5,236,557,905	5,119,350,966
Total capital and surplus	6,355,210,564	5,250,446,730
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 19,617,542,351	$ 17,922,647,014

See notes to statutory basis financial statements.

UNITEDHEALTHCARE INSURANCE COMPANY

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2017 AND 2016

	2017	2016
REVENUES:		
Premiums for life and accident and health contracts—net	$50,538,608,765	$44,379,154,081
Net investment income	514,866,037	821,679,394
Commissions and expense allowances on reinsurance ceded	208,676,126	104,166,470
Miscellaneous income	45,539,333	35,430,528
Total revenues	51,307,690,261	45,340,430,473
BENEFITS AND EXPENSES:		
Benefits under life and accident and health insurance contracts—net	40,552,584,195	35,046,441,712
Commissions on premiums	1,171,721,779	1,023,120,489
General insurance expenses	5,212,097,232	4,664,131,087
Insurance taxes, licenses, and fees, excluding federal income taxes	674,722,153	1,820,030,631
Total benefits and expenses	47,611,125,359	42,553,723,919
NET GAIN FROM OPERATIONS BEFORE FEDERAL INCOME TAXES AND NET REALIZED CAPITAL GAINS	3,696,564,902	2,786,706,554
FEDERAL INCOME TAXES INCURRED	1,130,820,262	875,233,668
NET GAIN FROM OPERATIONS AFTER FEDERAL INCOME TAXES AND BEFORE NET REALIZED CAPITAL GAINS	2,565,744,640	1,911,472,886
NET REALIZED CAPITAL GAINS (EXCLUDING GAINS (LOSSES) TRANSFERRED TO THE IMR OF $12,183,371 AND $43,829,647) LESS CAPITAL GAINS TAX OF $18,753,427 AND $7,674,867 IN 2017 AND 2016, RESPECTIVELY	33,843,376	13,175,389
NET INCOME	$ 2,599,588,016	$ 1,924,648,275

See notes to statutory basis financial statements.

UNITEDHEALTHCARE INSURANCE COMPANY

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2017 AND 2016

	Common Capital Stock		Gross Paid-In and Contributed Surplus	Section 9010 ACA Subsequent Fee Year Assessment	Unassigned Surplus	Total
	Shares	Amount				
BALANCE—January 1, 2016	500	$ 3,000,000	$ 128,095,764	$ 524,559,410	$ 4,934,084,053	$ 5,589,739,227
Net income	-	-	-	-	1,924,648,275	1,924,648,275
Change in asset valuation reserve	-	-	-	-	50,885,640	50,885,640
Cash dividends to parent	-	-	-	-	(2,175,000,000)	(2,175,000,000)
Change in net unrealized capital gains (losses) on investments tax of $3,393,504	-	-	-	-	(134,573,045)	(134,573,045)
Section 9010 ACA subsequent fee year assessment	-	-	-	(524,559,410)	524,559,410	-
Change in nonadmitted assets	-	-	-	-	(19,142,883)	(19,142,883)
Change in net deferred income taxes	-	-	-	-	13,889,516	13,889,516
BALANCE—December 31, 2016	500	3,000,000	128,095,764	-	5,119,350,966	5,250,446,730
Net income	-	-	-	-	2,599,588,016	2,599,588,016
Change in asset valuation reserve	-	-	-	-	(107,493,430)	(107,493,430)
Cash dividends to parent	-	-	-	-	(1,710,000,000)	(1,710,000,000)
Noncash dividend to parent	-	-	-	-	(60,000,000)	(60,000,000)
Capital contribution from parent	-	-	180,500,000	-	-	180,500,000
Change in net unrealized capital gains (losses) on investments less capital gains tax of $450,388	-	-	-	-	227,185,724	227,185,724
Section 9010 ACA subsequent fee year assessment	-	-	-	807,056,895	(807,056,895)	-
Change in accounting principles (Note 2)	-	-	-	-	125,946,628	125,946,628
Change in nonadmitted assets	-	-	-	-	52,620,043	52,620,043
Change in net deferred income taxes	-	-	-	-	(203,583,147)	(203,583,147)
BALANCE—December 31, 2017	500	$ 3,000,000	$ 308,595,764	$ 807,056,895	$ 5,236,557,905	$ 6,355,210,564

See notes to statutory basis financial statements.

UNITEDHEALTHCARE INSURANCE COMPANY

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2017 AND 2016

	2017	2016
CASH FLOWS FROM OPERATIONS:		
Premiums collected—net of reinsurance	$ 49,762,931,670	$ 43,855,203,335
Net investment income	584,092,412	836,236,577
Miscellaneous income	271,215,236	7,255,785
Benefit and loss related payments	(39,243,092,088)	(34,415,810,044)
Commissions and other expenses paid	(6,775,797,570)	(6,108,771,449)
Federal income taxes paid—net	(897,049,897)	(1,090,547,384)
Net cash provided by operating activities	3,702,299,763	3,083,566,820
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments:		
Bonds sold or matured	2,426,717,551	2,821,153,173
Stocks	329,732,297	244,212,103
Total investment proceeds	2,756,449,848	3,065,365,276
Cost of investments acquired:		
Bonds	(3,531,750,326)	(3,456,158,291)
Stocks	(342,563,288)	(220,437,380)
Properties occupied by the Company	(22,155,701)	(291,282,369)
Other invested assets	(67,614,779)	(764,520)
Total cost of investments acquired	(3,964,084,094)	(3,968,642,560)
Net cash used in investments	(1,207,634,246)	(903,277,284)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Dividends paid	(1,710,000,000)	(2,175,000,000)
Cash provided through (used in) net transfers from (to) affiliates	24,448,995	(20,619,249)
Capital contribution from parent	180,500,000	-
Other cash (applied) provided	(52,575,494)	367,030,942
Net cash used in financing and miscellaneous activities	(1,557,626,499)	(1,828,588,307)
RECONCILIATION OF CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	937,039,018	351,701,229
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS—Beginning of year	1,722,351,279	1,370,650,050
CASH OVERDRAFTS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS—End of year	$ 2,659,390,297	$ 1,722,351,279
DISCLOSURE OF NONCASH TRANSACTION—		
Change in accounting principle pursuant to SSAP No. 35R (see Note 2 in notes to the financials)	$ 125,946,628	$ -
Non-cash dividend to parent (see Note 10 in notes to the financials)	$ 60,000,000	$ -
Non-cash dividend received from affiliate (see Note 10 in notes to the financials)	$ -	$ 60,000,000

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare Insurance Company (the "Company"), licensed as a life, accident, and health insurer, is domiciled in the State of Connecticut. The Company is a wholly owned subsidiary of UHIC Holdings, Inc. ("UHIC"), whose parent is United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on March 24, 1972, as a life, accident, and health insurer, and operations commenced in April 1972. The Company is licensed to sell life and accident and health insurance in all states, with the exception of New York, and the District of Columbia, and primarily issues group accident and health insurance contracts to employers, government sponsored plans, and associations.

The Company offers comprehensive commercial products to individuals and employer groups. Each contract outlines the coverage provided and renewal provisions. The Company also participates in the Affordable Care Act ("ACA") small group exchange market in Maryland and the District of Columbia. In 2016, the Company also participated in the ACA individual exchange market in four states. Effective January 1, 2017, the Company exited the ACA individual exchange market in all states. The 2016 ACA individual exchange revenue represented less than 1% of total 2016 direct premiums written.

The Company has a contract with the Office of Personnel Management ("OPM") to provide healthcare services to employees of the federal government under the Federal Employee Health Benefit Plan ("FEHBP"). The contract has been renewed through December 31, 2018 and is subject to annual renewal provisions thereafter (see Note 24).

The Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage (collectively the "Medicare program") under a contract with the Centers for Medicare and Medicaid Services ("CMS"). Under the Medicare program, there are seven separate elements of payment received by the Company either during the year or at settlement in the subsequent year. These payment elements are CMS premium, member premium, CMS low-income premium subsidy, CMS catastrophic reinsurance subsidy, CMS low-income member cost-sharing subsidy, CMS risk share, and the CMS coverage gap discount program ("CGDP"). Each component of the Medicare program is further defined throughout Note 1.

The Company has a contract with CMS to also serve as a plan sponsor offering a Dual Special Needs Plan ("DSNP") product. This product is solely funded by CMS. A DSNP is a specialized type of Medicare Advantage Prescription Drug Plan ("MAPD") that is limited to dually eligible members and provides additional Medicaid coordination and clinical programs.

The Company provides health insurance products and services to members of the American Association of Retired Persons ("AARP") under a Supplemental Health Insurance Program (the "AARP Program"), and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 and 64 years of age, and other related products.

The Company's arrangements with AARP extend to December 31, 2025, with mutual options to further extend the relationship until the end of 2030, and give the Company exclusive right to use the AARP brand on the Company's Medicare Advantage and Medicare Part D offerings, subject to certain limited exclusions.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed and permitted by the Connecticut Insurance Department (the "Department").

The Department recognizes only statutory accounting practices, prescribed and permitted by the State of Connecticut, for determining and reporting the financial condition and results of operations of a life, accident, and health insurer, for determining its solvency under Connecticut Insurance Law. The state prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the statutory basis financial statements.

No significant differences exist between the practices prescribed and permitted by the State of Connecticut and those prescribed and permitted by the NAIC SAP, which materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

Net Income	SSAP #	AFS Line	2017	2016
(1) Company state basis	XXX	XXX	$ 2,599,588,016	$ 1,924,648,275
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: None			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: None			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 2,599,588,016	$ 1,924,648,275
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 6,355,210,564	$ 5,250,446,730
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: None			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: None			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 6,355,210,564	$ 5,250,446,730

B. Use of Estimates in the Preparation of the Statutory Basis Financial Statements

The preparation of these statutory basis financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to aggregate reserves for life and accident and health contracts, benefits under life and accident and health insurance contracts-net, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation—The Company prepares its statutory basis financial statements on the basis of accounting practices prescribed and permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds and short-term investments are stated at book/adjusted carrying value if they meet NAIC designation of one through five and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of six. The Company does not have any mandatory convertible securities or Securities Valuation Office ("SVO") identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds and short-term investments are valued and reported using market prices published by the SVO of the NAIC in accordance with the NAIC Valuations of Securities manual prepared by the SVO or an external pricing service;

(3–4) Common and preferred stocks include affiliated common stocks, which are carried at the underlying statutory equity value for insurance and health plan affiliates. The Company also holds non-affiliated common stocks which are valued and reported using market prices published by the SVO in accordance with the NAIC Valuations of Securities manual prepared by the SVO or an external pricing service. Changes in value of affiliated and non-affiliated common stocks are recorded as a change in unassigned surplus. Preferred stocks are nonaffiliated and have a carrying value that is calculated in accordance with the guidance set forth in Statements of Statutory Accounting Principles ("SSAP") No. 32, Investments in Preferred Stock (including investments in preferred stock of subsidiary, controlled, or affiliated entities);

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company owns 100% of Oxford Health Insurance, Inc. ("OHI"), UnitedHealthcare Insurance Company of New York ("UHIC NY"), UnitedHealthcare Insurance Company of Illinois ("UHIC IL"), UnitedHealthcare of New Mexico ("UHC NM") and Unimerica Life Insurance Company of New York ("ULIC NY"). These are accounted for under the statutory equity method and are included in common stocks in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, this investment would be consolidated;

(8) The Company has investment interests with respect to joint ventures, partnerships or limited liability companies;

(9) The Company holds no derivatives;

(10) Premium deficiency reserves (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate reserves for life and accident and health contracts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and, therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE, and direct administration costs are considered. The methods for making such estimates and for establishing the resulting reserves are periodically reviewed and updated, and any adjustments are reflected in benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations in the period in which the change in estimate is identified. The Company anticipates investment income as a factor in the premium deficiency calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for administrative and management services. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid CAE as of December 31, 2017 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) Maintenance and repairs that do not improve or extend the life of the respective assets are expensed in the period incurred and included in general insurance expenses in the statutory basis statements of operations. The Company has not modified its capitalization policy from the prior period.

On March 29, 2016, the Company purchased real estate from UHS, an affiliate, at fair value (see Note 10). The actual cost at the time of acquisition was $291,014,859, and additional investments of $155,701 and $267,510 were made in 2017 and 2016, respectively, after the acquisition.

Effective January 1, 2017, the Company transferred the real estate at book value to EP Campus I, LLC ("EP Campus"), a wholly owned subsidiary of the Company (see Note 10).

On October 16, 2017, 5995 Minnetonka, LLC ("5995 Minnetonka"), a wholly owned subsidiary of the Company (see Note 10) purchased real estate from an unaffiliated seller. The actual cost at the time of acquisition was $22,000,000.

Both EP Campus and 5995 Minnetonka own a single real estate property which is more than 50% occupied by the Company or its affiliates. Pursuant to SSAP No. 40R, *Real Estate Investments* ("SSAP 40R"), the Company reports both real estate properties as properties occupied by the Company in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

Effective March 29, 2016 the Company entered into a long-term lease agreement for EP Campus with UHS. The initial term of the agreement is 20 years, with the annual rental amount increasing in each year, through year 15. The agreement also provides UHS with four extension options, of 5 years each, with redetermination of the annual rental amount in the first year of each extension period, as defined in the agreement. Under this agreement, the Company has recorded rental income of $17,854,590 and $13,222,385, which is included in net investment income in the statutory basis statements of operations for the years ended December 31, 2017 and 2016, respectively. The Company imputes rental income in accordance with the NAIC SAP principles.

Under SSAP 40R, property occupied by the Company is carried at depreciated cost less encumbrances unless events or circumstances indicate the carrying amount of the asset may not be recoverable. The Company calculates depreciation using the straight-line method over the estimated useful lives of the property, excluding land, which is 35-40 years for property occupied by the Company and 7 years for improvements. An impairment loss is recognized when the individual carrying amounts exceed the fair value. The new cost basis shall not be changed for subsequent recoveries in fair value. The Company did not recognize any impairment losses on properties occupied by the Company in 2017 or 2016.

Depreciation expense on properties occupied by the Company of $12,650,328 and $9,174,960 in 2017 and 2016, respectively, is netted against net investment income in the statutory basis statements of operations.

The components of properties occupied by the Company at December 31, 2017 and 2016 are as follows:

Properties Occupied by the Company	**2017**	**2016**
Land, buildings, and improvements	$313,438,070	$291,282,369
Less accumulated depreciation	(21,825,288)	(9,174,960)
Properties occupied by the Company	291,612,782	282,107,409
Less nonadmitted land, buildings, and improvements	-	-
Net admitted properties occupied by the Company	$291,612,782	$282,107,409

(13) Health care and other amounts receivable consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care and other amounts receivable also include receivables for amounts due to the Company for provider advances and claim overpayments to providers, hospitals, and other health care organizations. Health care and other amounts receivable are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 28).

The Company has also deemed the following to be significant accounting policies and/or differences between statutory practices and GAAP:

ASSETS

Cash and Invested Assets

- Bonds include U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities with a maturity of greater than one year at the time of purchase;

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the statutory basis financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively;

- Investments in common stocks and preferred stocks are valued as prescribed by the SVO, or an external pricing service if NAIC values are not available, in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, common stocks and preferred stocks are generally reported at fair value;

- Cash overdrafts, cash equivalents, and short-term investments in the statutory basis financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date;

- Cash represents cash held by the Company in disbursement accounts and certificates of deposit with a maturity date of less than one year from acquisition. Claims and other payments are made from the disbursement accounts daily. Cash overdrafts are a result of timing differences in funding disbursement accounts for claims payments;

- Outstanding checks are required to be netted against cash balances or presented as cash overdrafts if in excess of cash balances in the statutory basis statements of admitted assets, liabilities, and capital and surplus as opposed to being presented as other liabilities under GAAP;

- Cash equivalents include money market funds, U.S. treasury bills, certificates of deposit, corporate debt securities, and commercial paper. In 2016, money-market funds were classified as a component of short-term investments. Cash equivalents have original maturity dates of three months or less from the date of acquisition. Cash equivalents, excluding money-market funds, are reported at cost or book/adjusted carrying value depending on the nature of the underlying security, which approximates fair value. Money-market funds are reported at fair value or net asset value as a practical expedient;

- Short-term investments include corporate debt securities, U.S. government and agency securities, state and agency municipal securities, and in 2016, money-market funds. In 2017, money-market funds are now classified as cash equivalents. Short-term investments have a maturity of greater than three months but less than one year at the time of purchase. Short-term investments also consist of the Company's share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number

to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or book/adjusted carrying value depending on the composition of the underlying securities. Interest income from the pool accrues daily to participating members based upon ownership percentage;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses, except for those transferred to the Interest Maintenance Reserve ("IMR"), are reported as net realized capital gains (excluding gains (losses) transferred to the IMR) less capital gains tax in the statutory basis statements of operations. Transfers to the IMR are net of federal income taxes;

- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital gains (excluding gains (losses) transferred to the IMR) less capital gains tax in the statutory basis statements of operations. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition. The Company recognized other-than-temporary impairments ("OTTIs") of $1,321,890 and $7,624,799 for the years ended December 31, 2017 and 2016, respectively;

- The statutory basis statements of cash flows reconcile cash overdrafts, cash equivalents, and short-term investments with original maturities of one year or less from the time of acquisition; whereas under GAAP, the statements of cash flows reconcile the corresponding captions of cash and cash equivalents with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Other Invested Assets—Other invested assets include low-income housing tax credit ("LIHTC") investments which are stated at book/adjusted carrying value, which approximates fair value, in the statutory basis statements of admitted assets, liabilities and capital and surplus. Other invested assets also includes the Company's share as a limited partner in the Wellington Emerging Markets Fund and is stated at book/adjusted carrying value, which approximates fair value, in the statutory basis statements of admitted assets, liabilities and capital and surplus.

Receivables for Securities—The Company reports receivables for securities when investments are sold at the end of an accounting period and proceeds are received in a subsequent month in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Any receivables for securities not received within 15 days from the settlement date are nonadmitted.

Other Assets

- **Investment Income Due and Accrued**—Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment income due and accrued in the statutory

basis statements of admitted assets, liabilities, and capital and surplus. The Company evaluates the collectability of the amounts due and accrued and amounts determined to be uncollectible are written off in the period in which the determination is made. In addition, the remaining balance is assessed for admissibility and any balance greater than 90 days past due is considered a nonadmitted asset.

- **Premiums and Considerations**—The Company reports uncollected premium balances from its insured members as premiums and considerations in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Uncollected premium balances that are over 90 days past due, with the exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include the following:

  a) risk adjustment receivables, as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. A risk adjustment receivable is recorded when the Company estimates its average actuarial risk score for policies included in this program is greater than the average actuarial risk scores in that market and state risk pool;

  b) CMS risk adjustment receivables. The risk adjustment model apportions premiums paid to all plans according to the health severity and certain demographic factors of its enrollees. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk-adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. The Company recognizes such changes when the amounts become determinable and supportable and collectability is reasonably assured.

  Premium adjustments for the ACA Section 1343 risk adjustment and CMS risk adjustment programs are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans**—Receivables for amounts held under uninsured plans represent the costs incurred in excess of the cost reimbursement under the Medicare program for the catastrophic reinsurance subsidy and the low-income member cost-sharing subsidy for the individual members. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Subsidies for individual members are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. If the Company incurs costs in excess of these subsidies, a corresponding receivable is recorded in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Related cash flows are presented within commissions and other expenses paid within net cash provided by operations in the statutory basis statements of cash flows. For employer group members, the cost reimbursement under the Medicare program for the catastrophic reinsurance subsidy is consistent with reimbursement for individuals. The low-income member cost-sharing subsidy for employer group members is only received at settlement which is in the subsequent year. The ACA mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. As part of the CGDP,

the Company records a receivable from the pharmaceutical manufacturers for reimbursement of the discounts which is included in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. There are no similar subsidies for employer group members. Related cash flows are presented within commissions and other expenses paid within net cash provided by operations in the statutory basis statements of cash flows. The Company solely administers the application of these funds and has no insurance risk.

Some groups opt to participate in the partial self-funded plan, under which a portion of claims payments are funded by the groups after claims are processed. The amounts receivable relating to uninsured plans represent monies due to the Company under the self-insured portion of the plan for claims awaiting funding. Amounts receivable relating to uninsured plans also include monies advanced by the Company under the aggregate cash flow option to groups that have opted for this feature in accordance with their participation in the partial self-funded plan offered by the Company.

- **Current Federal Income Tax Recoverable**—The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A current federal income tax recoverable is recognized when the Company's allocated intercompany estimated payments are more than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Net Deferred Tax Asset**—The NAIC SAP provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under the NAIC SAP, the change in deferred tax assets is recorded directly to unassigned surplus in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets is recorded as a component of the income tax provision within the income statement and is based on the ultimate recoverability of the deferred tax assets. Based on the admissibility criteria under the NAIC SAP, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheet.

- **Other Assets**—The Company recognizes guaranty funds receivable when it is probable that a paid or accrued assessment will result in an amount that is recoverable from premium tax offsets. The receivable amount is determined based on current laws, projections of future premium collections from in-force policies, and as permitted by NAIC SAP. In-force policies do not include expected renewals of short-term contracts except in cases when retrospective-premium-based assessments are imposed on short-duration contracts for losses on long-duration contracts. In which case, appropriate renewal rates based on persistency for the in-force short-duration contracts are taken into consideration when recognizing the asset (see Note 14). Any recognized asset from premium tax credits is re-evaluated regularly to ensure recoverability.

LIABILITIES

- **Aggregate Reserves for Life and Accident and Health Contracts and Contract Claims**—The reserves for disability, accidental death, and life insurance are developed by actuarial methods and are determined based on published or established tables, using

interest rates less than or equal to statutorily prescribed interest rates, and valuation methods that will provide, in the aggregate, reserves that are greater than or equal to the minimum or guaranteed cash values or the amounts required by the Department. Tabular interest, tabular less actual reserve released, tabular cost, and tabular interest on funds not involving life contingencies are determined by a formula in accordance with the State of Connecticut statutes. Contract claims reserves include claims processed but not yet paid, estimates for claims received but not yet processed, and estimates for the costs of health care services enrollees have received, but for which claims have not yet been submitted.

The estimates for aggregate reserves and incurred but not reported contract claims are developed using actuarial methods based upon historical data for payment patterns, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during the years ended December 31, 2017 and 2016. Adjustments to estimates for aggregate reserves for life and accident and health contracts are reflected in operating results in the period in which the change in estimate is identified.

Aggregate reserves are based on mortality and interest assumptions prescribed and permitted by state statutes without consideration of withdrawals. Statutory reserves may differ from reserves based on the Company's estimates of mortality, interest, and withdrawals; receivables on unpaid claims for coinsurance contracts are netted against contract claims in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, the receivables would be presented as assets.

The reserves ceded to reinsurers for aggregate reserves for life and accident and health contracts and contract claims have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

Aggregate reserves for life and accident and health contracts and contract claims also include risk adjustment payables as defined in Section 1343 of the ACA. Premium adjustments are based upon the risk scores (health status) of enrollees participating in risk adjustment covered plans, rather than the actual loss experience of the insured. A risk adjustment payable is recorded when the Company estimates its average actuarial risk score for policies included in this program is less than the average actuarial risk scores in that market and state risk pool (see Note 24);

The Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any surpluses in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentage and the liability is included in contract claims in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has incentive and bonus arrangements with providers that are based on quality, utilization, and/or various health outcome measures. The estimated amount due to providers that meet the established metrics is included in contract claims in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Unearned Premiums**—The unexpired portion of accident and health insurance premiums received is reported as part of aggregate reserves for life and accident and health contracts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Liability for Deposit-Type Contracts**—Consideration for annuities and other deposit-type contracts that do not involve any mortality or morbidity risks are recorded as liability for deposit-type contracts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Revenues for these contracts include fees charged to policyholders and net investment income in the statutory basis statements of operations.

- **Premiums for Life and Accident and Health Contracts Received in Advance**—Premiums received in full during the current period that are not due until future periods are recorded as premiums for life and accident and health contracts received in advance in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Provision for Experience Rating Refunds**—The Company establishes a liability, net of ceded reinsurance, for estimated accrued retrospective and redetermination premiums due from the Company based on the actuarial method and assumptions for each respective contract. Provision for experience rating refunds also includes:

  a) risk corridor payable as defined in Section 1342 of the ACA. Premium adjustments are based on each qualified health plan's allowable costs in relation to a target amount. A risk corridor payable is recorded when the allowable costs are below 97 percent of the target amount (see Note 24);

  b) CMS risk corridor payables for which adjustments are based on whether the ultimate PMPM benefit costs of any Medicare program plan varies more than 5% below the level estimated in the original bid submitted by the Company and approved by CMS (see Note 24);

  c) estimated rebates payable on the comprehensive commercial, Medicaid, and Medicare products, if the medical loss ratios on these fully insured products, as calculated under the definitions of the ACA and/or State statutes (see Note 14) and implementing regulations, fall below certain targets. The Company is required to rebate the ratable portions of the premiums annually (see Note 24), and

  d) the Company's contract with AARP requires the Company to fund any deficit if cumulative net losses were to exceed that part of the experience rated refund liability attributable to AARP. Any deficit the Company funded could be recovered by underwriting gains in future periods. When the Company entered into the AARP contract, the Company assumed the policy liabilities related to the AARP program and received cash, investments, and premium receivables from the previous insurance carrier equal to the carrying value of those liabilities as of the contract inception date (see Note 24).

- **IMR and Asset Valuation Reserve ("AVR")**—The Company maintains an IMR and an AVR. The IMR is designed to defer recognition of realized capital gains and losses, due to interest rate changes on fixed-income investments, and to amortize those gains and losses into future investment income over the remaining life of the investments sold. To the extent the deferral of capital losses results in a net asset, such amount will be nonadmitted and excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus. The AVR is designed to address the default and equity risk on the majority of the Company's invested assets. The principal function of the AVR is to reserve for credit losses on fixed-income securities carried at amortized values and for fluctuation in statutory capital and surplus resulting from realized gains and losses and changes in unrealized gains and losses.

The IMR is determined based on a formula prescribed by the NAIC whereby the Company defers the portion of realized capital gains and losses on sales of fixed-income investments, principally bonds, attributable to changes in the general level of interest rates and amortizes these deferrals over the remaining period to maturity based on groupings of individual securities sold in five year bands, rather than recognize the realized gains and losses currently. Further, the AVR is determined by the NAIC-prescribed formulas and is reported as a liability rather than as a valuation allowance or appropriation of unassigned surplus in the statutory basis financial statements. Under GAAP, realized capital gains and losses are reported in the statements of operations on a pre-tax basis in the period that the asset giving rise to the gain or loss is sold and calculation of allowances are provided where there has been a decline in value deemed other-than-temporary, in which case, the provision for such decline is charged to earnings.

- **Commissions to Agents Due or Accrued**—Commissions that are due as of the reporting date that have been incurred but not yet paid are reported as other liabilities in the statutory basis statement of admitted assets, liabilities, and capital and surplus.

- **General Expenses Due or Accrued**—General expenses that are due as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Current Federal Income Taxes Payable**—The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A liability for federal income taxes payable is recognized when its allocated intercompany estimated payments are less than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Taxes, Licenses, and Fees Due or Accrued, Excluding Federal Income Taxes ("TL&F")**—TL&F represents insurance assessments, state taxes on premium and income, and state insurance department licenses and fees. TL&F is recognized when incurred. Taxes, licenses and fees that are due as of the reporting date in addition to taxes, licenses, and fees that have been incurred but are not due until a subsequent period are reported as TL&F in the statutory basis statements of admitted assets, liabilities, and capital and surplus. TL&F also include the unpaid portion of the contributions required under the ACA risk adjustment and reinsurance programs (see Note 24).

- **Remittances and Items Not Allocated**—Remittances and items not allocated generally represent monies received from policyholders for monthly premium billings or providers that have not been specifically identified or applied prior to year-end. The majority is from monies received in the lockbox account on the last day of the year.

- **Payable to Parent, Subsidiaries, and Affiliates, Net**—In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts owed as amounts payable to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Liability for Amounts Held Under Uninsured Plans**—Liability for amounts held under uninsured plans represents costs incurred that are less than the cost reimbursement under the Medicare program for the catastrophic reinsurance subsidy and the low-income

member cost-sharing subsidy for the individual members. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Subsidies for individual members are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. If the Company incurs costs less than these subsidies, a corresponding liability is recorded in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Related cash flows are presented within operating expenses paid within net cash provided by operations in the statutory basis statements of cash flows. For employer group members, the cost reimbursement under the Medicare program for the catastrophic reinsurance subsidy is consistent with reimbursement for individuals. The low-income member cost-sharing subsidy for employer group members is only received at settlement which is in the subsequent year. The ACA mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are pre-funded for the individual members by CMS and a liability for the amount subject to recoupment is recorded in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. There are no similar subsidies for employer group members. Related cash flows are presented within commissions and other expenses paid within net cash provided by operations in the statutory basis statements of cash flows. The Company solely administers the application of these funds and has no insurance risk.

Liability for amounts held under uninsured plans also include the cost reimbursement for the cost sharing reduction ("CSR") components of the ACA. The Company is fully reimbursed by the federal government for costs incurred related to these provisions. The Company receives advances that are applied to eligible claims. If the Company incurs costs that are less than these subsidies, a corresponding liability is recorded as amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Payable for Securities**—The Company reports payable for securities when investments are traded at the end of an accounting period for which the settlement does not occur until the following month in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets**—Certain assets, including certain aged premium receivables, certain health care and other amounts receivable, certain deferred tax assets, prepaid expenses, certain receivables from affiliates, and amounts receivable relating to uninsured plans, are considered nonadmitted assets under the NAIC SAP and are excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus and charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheet.

- **Restricted Cash Reserves**—The Company held regulatory deposits in the amount of $2,012,411 and $2,429,115 as of December 31, 2017 and 2016, respectively, in compliance with the various states requirements for qualification purposes as a domestic and foreign insurer. These restricted cash reserves consist principally of government obligations and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds and short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Interest earned on these deposits accrues to the Company.

- **Minimum Capital and Surplus**—Under the laws of the State of Connecticut, the Company's domiciliary state, the Department requires the Company to maintain a minimum capital and surplus equal to $3,000,000.

Risk-based capital ("RBC") is a regulatory tool for measuring the minimum amount of capital appropriate for a life, accident, and health organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula.

The Company is also subject to minimum capital and surplus requirements in other states where it is licensed to do business.

The Company has $6,335,210,564 and $5,250,446,730 in total statutory basis capital and surplus as of December 31, 2017 and 2016, respectively, which is in compliance with the required amounts where it is licensed to do business.

- **Section 9010 ACA Subsequent Fee Year Assessment**—The Company is subject to the Section 9010 ACA subsequent fee year assessment. Under the NAIC SAP, an amount equal to the estimated subsequent year fee must be apportioned out of unassigned surplus and reported as Section 9010 ACA subsequent fee year assessment in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, no such special surplus designation is required. In accordance with the 2017 Health Insurer Fee ("HIF") moratorium, no HIF was payable in 2017, therefore no amounts were apportioned out in the 2016 statutory basis statements of admitted assets, liabilities, and capital and surplus.

STATEMENTS OF OPERATIONS

- **Premiums for Life and Accident and Health Contracts—Net**—Premiums for life and accident and health contracts—net are recognized in the period in which enrollees are entitled to receive services and are shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the statutory basis statements of operations. The corresponding change in unearned premium from year to year is reflected as an increase (decrease) in benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations. Under GAAP, the change in unearned premium from year to year on the accident and health insurance premiums is reported through premium income.

  Comprehensive commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the ACA (see Note 14) and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as premiums for life and accident and health contracts—net in the statutory basis statements of operations.

  Pursuant to Section 1342 and Section 1343 of the ACA, the Company records premium adjustments for changes to the risk corridor and risk adjustment balances which are reflected in premiums for life and accident and health contracts—net in the statutory basis statements of operations.

  Premiums for life and accident and health contracts—net includes premium under the Medicare program, which includes CMS premium, member premium, and CMS low-income premium subsidy for the Company's insurance risk coverage. It also includes premium under the DSNP program. Net premium income is recognized ratably over the period in which eligible individuals are entitled to receive health care services and prescription drug benefits.

Premiums for life and accident and health contracts—net also includes amounts pursuant to the CMS risk adjustment program. The Company recognized $39,764,962 and $12,239,766 for changes in prior year Medicare risk factor estimates during the years ended December 31, 2017 and 2016, respectively, which is recorded as premiums for life and accident and health contracts—net in the statutory basis statements of operations.

The Company also records estimates related to the CMS risk corridor program. Changes to these estimates are reflected as premiums for life and accident and health contracts—net in the statutory basis statements of operations.

Medicare Advantage plans and Part D prescription drug plans are subject to medical loss ratio requirements under the ACA. Plans with medical loss ratios that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as premiums for life and accident and health contracts—net in the statutory basis statements of operations.

Premiums for life and accident and health contracts—net also includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under Medicaid programs. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company. The majority of premiums for life and accident and health contracts—net recorded is based on capitated rates, which are monthly premiums paid for each member enrolled.

The Company has recorded receivables/payables from employer groups for estimated retrospective premium adjustments due to/from the Company based on the underlying contractual terms that are recorded as premiums for life and accident and health contracts—net in the statutory basis statements of operations.

- **Net Investment Income**—Net investment income includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and certain external investment management costs are also included in net investment income (see Note 7).

  Under SSAP No. 97—*Investments in Subsidiary, Controlled, and Affiliated Entities, A Replacement of SSAP No. 88*, dividends or distributions received from an investee are recognized in net investment income when declared to the extent that they are not in excess of the undistributed accumulated earnings attributable to the investee. The dividends or distributions are recorded as a return of capital if the amount exceeds the undistributed accumulated earnings attributable to the investee. Dividends received from subsidiary investees during 2017 and 2016, were $306,800,000 and $654,200,000, respectively, and are recorded as net investment income in the statutory basis statements of operations. These dividends qualify for tax-free treatment as a result of the federal dividends received deduction.

- **Commissions and Expense Allowances on Reinsurance Ceded**—Commissions and expense allowances on reinsurance ceded represents expense allowances related to the Company's quota share contract, medical stop loss reinsurance contracts, and short-term and long-term contracts. Commissions and expense allowances are recorded when earned based on the contract period. Commissions and expense allowances on reinsurance ceded were $208,676,126 and $104,166,470 for the years ended December 31, 2017 and 2016, respectively, and are included in commissions and expense allowances on reinsurance ceded in the statutory basis statements of operations.

- **Benefits under Life and Accident and Health Insurance Contracts—Net**—Death benefits and changes in aggregate reserves for life contracts includes life claims paid, life claims processed but not yet paid, estimates for life claims received but not yet processed, estimates for life claims where the death has occurred but for which a claim has not been submitted and changes in contract and policy reserves. Benefits under life and accident and health insurance contracts—net and changes in aggregate reserves for accident and health contracts include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, payments and liabilities for physician, hospital, and other medical costs disputes, estimates for payments not yet due on incurred claims, and changes in contract and policy reserves.

- **Commissions on Premiums**—Commissions on premiums represent commission expense for external brokers and agents. Expense is recorded when incurred based upon the contract period.

- **Commissions and Expense Allowances on Reinsurance Assumed**—Commissions and expense allowances on reinsurance assumed represents general expenses and TL&F related to assumed premiums on the Company's quota share agreements with affiliates (See Note 10) and nonaffiliates (See Note 23). Commissions and expense allowances on reinsurance assumed were $344,090,777 and $334,992,282 for the years ended December 31, 2017 and 2016, respectively, and are included in general insurance expenses in the statutory basis statements of operations.

- **General Insurance Expenses**—Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general insurance expenses to be reported in the statutory basis statements of operations.

  Administrative fee revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under these contracts, the Company recognizes revenue in the period in which the related services are performed. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premiums for life and accident and health contracts—net and disability benefits and benefits under accident and health insurance contracts for these contracts. Administrative fee revenue and related expenses are netted against general insurance expenses in the statutory basis statements of operations (see Note 18).

- **Insurance Taxes, Licenses and Fees, Excluding Federal Income Taxes ("Insurance TL&F")**—Insurance TL&F represents insurance assessments, state taxes on premium and income, and state insurance department licenses and fees. Insurance TL&F is recognized when incurred. The Company is subject to an annual fee under Section 9010 of the ACA. A health insurance entity's annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, 2014, which is nondeductible for tax purposes. Under the NAIC SAP, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in insurance taxes, licenses and fees, excluding federal income taxes in the statutory basis statements of operations, whereas under GAAP, a deferred asset is created on January 1 of the fee year which is amortized to expense on a straight-line basis throughout the year.

- **Federal Income Taxes Incurred**—The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 35% to net gain from operations before federal income taxes and net realized capital gains subject to certain adjustments (see Note 9).

- **Comprehensive Income**—Comprehensive income and its components are not separately presented in the statutory basis financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

REINSURANCE

- **Reinsurance Ceded**—In the normal course of business, the Company seeks to limit its exposure to loss on any single insured and to recover a portion of benefits paid by ceding premium to other insurance enterprises or reinsurers under excess coverage contracts or specific transfer of risk agreements. The Company remains primarily liable as the direct insurer on the risks reinsured. Reinsurance premiums paid and reinsurance premiums incurred but not paid are deducted from premiums for life and accident and health contracts—net in the statutory basis statements of operations. Any amounts due to the Company pursuant to these agreements are recorded as reinsurance in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 10 and Note 23).

  Effective July 1, 2016, the Company entered into a quota-share reinsurance agreement with Canada Life Assurance Company ("Canada Life"), under which the Company cedes 20% of the premiums earned and claims paid, subject to a stop loss limit, related to the reinsured policies (see Note 23). In addition, 20% of the statutory reserves on the reinsured policies as of the effective date, and subsequent changes in those reserves, are ceded to Canada Life on a funds withheld basis. The agreement also provides for an expense allowance and has an experience refund provision.

- **Reinsurance Assumed**—In the normal course of business, the Company enters into various insurance agreements with affiliates and nonaffiliates to assume reinsurance, primarily related to its health products. Reinsurance assumed from nonaffiliates primarily serves to expand the book of business and enhance business relations. Reinsurance assumed from affiliates limits or reduces the risk to affiliates.

- **Funds Held by or Deposited with Reinsured Companies**—The Company is deemed a certified reinsurer by the state of New York. As a result, the premiums due from UHIC NY under the bulk reinsurance agreement are not fully paid to the Company, and a portion is withheld pursuant to the reinsurance agreement (see Notes 10 and 23).

- **Amounts Recoverable from Reinsurers**—The Company records amounts recoverable from reinsurers, which represents amounts contractually due to the Company under the quota share reinsurance agreement between the Company and ceding insurers (See Notes 10 and 23), as reinsurance in the statutory basis statements of admitted assets, liabilities, and capital and surplus, and as benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations.

- **Section 1341 ACA Transitional Reinsurance**—The Company has established receivables of $1,450,753 and $5,076,385 and liabilities of $0 and $809,825 as of December 31, 2017 and 2016, respectively, pursuant to Section 1341 of the ACA, which are included in reinsurance and other amounts payable on reinsurance in the statutory basis statements of admitted assets, liabilities, and capital and surplus. This program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations (see Note 24).

- **Funds Held under Coinsurance**—Under the quota-share reinsurance agreement with Canada Life, funds withheld were $186,019,707 and $166,040,911 as of December 31, 2017 and 2016, respectively (see Note 23).

OTHER

- **Vulnerability Due to Certain Concentrations**—The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

  The Company has one customer that accounted for 19% and 21% of total direct premiums written for the years ended December 31, 2017 and 2016, respectively. The Company has one customer that accounted for 37% and 40% of premiums and considerations as of December 31, 2017 and 2016, respectively.

  Direct premiums written and premiums and considerations from members and CMS related to Medicare program as a percentage of total direct premiums written and total premiums and considerations are 26% and 29% as of December 31, 2017 and 22% and 26% as of December 31, 2016, respectively.

Recently Issued Accounting Standards—In March 2017, the NAIC revised SSAP No. 35R, *Guaranty Fund and Other Assessments* ("SSAP No. 35R") for the accounting and disclosure requirements related to the required discounting of liabilities and assets related to assessments from insolvencies of entities that wrote long-term care contracts. This revised guidance is effective for reporting periods after January 1, 2017. The Company adopted the revised accounting and disclosure requirements in 2017, and the impact is disclosed in Note 2 and Note 14.

In March 2017, the NAIC revised SSAP No. 2R, *Cash, Drafts, and Short-Term Investments* ("SSAP No. 2R") for the presentation of money-market fund balances. Money-market funds are now included as a component of cash equivalents in 2017, whereas in 2016, money-market funds were included as a component of short-term investments. This revised guidance is effective for reporting periods on and after December 31, 2017. The Company adopted the revised change in presentation in 2017.

In April 2017, the NAIC revised SSAP No. 26R, *Bonds* ("SSAP No. 26R") for the measurement method of mandatory convertible securities and SVO identified funds (i.e.: exchange traded funds and bond mutual funds) investments. The Company has adopted the revised guidance effective December 31, 2017. This guidance did not have a material impact to the statutory basis financial statements.

The Company reviewed all other recently issued guidance in 2017 and 2016 that has been adopted for 2017 or subsequent years' implementation and has determined that none of the items would have a significant impact to the statutory basis financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTION OF ERRORS

Effective March 2017, the Company adopted the revised accounting and disclosure requirements of SSAP No. 35R (see Note 1). As a result of this adoption, the Company recorded the net difference between the undiscounted and discounted guaranty association assessment liability and associated premium tax credit asset, net of tax, as a change in accounting principle in the statutory basis statements of changes in capital and surplus. This change is reported as a non-cash transaction in the statutory basis statements of cash flows.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2017 and 2016, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2017 and 2016.

B. Change in Plan of Sale of Discontinued Operation—Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal—Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal—Not applicable.

5. INVESTMENTS AND OTHER INVESTED ASSETS

Money-market funds activity is now included as a component of cash equivalents in 2017, whereas in 2016, money-market funds activity was included as a component of short-term investments. The amounts in the following disclosures and corresponding tables reflect this change in presentation. The Company's share of the investment pool sponsored and administered by UHS (see Note 1) is classified as a short-term investment. For presentation purposes, in 2016 the Company's share of the investment pool was reported in money-market funds whereas in 2017, the balance is reported in corporate debt securities.

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $75,272,803 and $9,179,883, respectively, for 2017 and $90,237,204 and $18,040,553, respectively, for 2016. The gross realized gains and losses on sales of short-term investments were $2,005 and $13,003, respectively, for 2017 and $5 and $0, respectively, for 2016. The net realized gain is included in net realized capital gains (excluding gains (losses) transferred to the IMR) less capital gains tax in the statutory basis statements of operations. Total proceeds on the sale of long-term investments were $1,294,944,164 and $2,205,872,434 and for short-term investments, were $48,480,396,462 and $50,021,255,676 in 2017 and 2016, respectively.

As of December 31, 2017 and 2016, the book/adjusted carrying value, fair value, and gross unrealized holding gains and losses of the Company's investments, excluding cash overdrafts and cash equivalents of $760,325,833 and $(112,683,708), respectively, are as follows:

	2017				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 1,901,490,098	$ 3,964,854	$ 5,947,462	$15,901,835	$ 1,883,605,655
State and agency municipal securities	833,115,229	14,486,435	2,429,290	1,014,661	844,157,713
City and county municipal securities	895,341,983	19,552,961	1,256,024	972,009	912,666,911
Corporate debt securities (includes commercial paper)	6,318,052,732	53,943,255	8,439,050	5,681,370	6,357,875,567
Other invested assets	232,867,903	272,233	36,968	22,088,268	211,014,900
Total bonds, short-term investments, and other invested assets	$10,180,867,945	$ 92,219,738	$18,108,794	$45,658,143	$10,209,320,746

	2017				
	Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value [1]
Investment in subsidiaries	$ 1,031,357,446	$1,104,350,718	$ -	$ -	$ 2,135,708,164
Preferred stocks	15,482,258	2,117,167	103,211	-	17,496,214
Mutual funds	43,759,312	172,202	5,786	11,792,717	32,133,011
Unaffiliated common stocks	364,455,952	24,117,804	5,327,966	2,339,648	380,906,142
Stocks	$ 1,455,054,968	$1,130,757,891	$ 5,436,963	$14,132,365	$ 2,566,243,531

[1] Investment in subsidiaries are reported using statutory equity

	2017				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value
Less than one year	$ 2,782,171,324	$ 4,215,328	$ 834,793	$ 256,684	$ 2,785,295,175
One to five years	2,716,595,362	19,415,934	7,130,212	5,170,939	2,723,710,145
Five to ten years	2,584,157,021	37,001,033	5,797,963	9,174,480	2,606,185,611
Over ten years	2,097,944,238	31,587,443	4,345,826	31,056,040	2,094,129,815
Total bonds, short-term investments, and other invested assets	$10,180,867,945	$ 92,219,738	$18,108,794	$45,658,143	$10,209,320,746

	2016				
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Fair Value
U.S. government and agency securities	$1,615,198,857	$ 7,009,325	$23,919,559	$ 382,545	$1,597,906,078
State and agency municipal securities	689,153,691	5,042,808	7,584,963	-	686,611,536
City and county municipal securities	811,521,863	7,145,826	9,877,382	-	808,790,307
Corporate bonds (includes commercial paper)	4,188,730,047	46,111,308	17,134,419	3,543,189	4,214,163,747
Money-market funds	1,511,420,118	-	-	-	1,511,420,118
Other invested assets	187,228,621	18,860	174,836	26,335,244	160,737,401
Preferred stocks	14,952,718	1,643,678	5,147	244,998	16,346,251
Total bonds, short-term investments, preferred stocks, and other invested assets	$9,018,205,915	$ 66,971,805	$58,696,306	$30,505,976	$8,995,975,438

	2016				
	Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses < 1 Year	Gross Unrealized Holding Losses > 1 Year	Statutory Value
Investment in subsidiaries	$1,031,357,446	$889,351,338	$ -	$ -	$1,920,708,784
Mutual funds	41,939,853	21,913	59,489	14,057,205	27,845,072
Unaffiliated common stocks	302,254,056	23,831,053	7,099,300	1,029,458	317,956,351
Common stocks	$1,375,551,355	$913,204,304	$ 7,158,789	$15,086,663	$2,266,510,207

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $1,230,162,926 and fair value of $1,223,596,820.

Common stocks include statutory operations of the Company's insurance subsidiaries, OHI, UHIC NY, UHIC IL, UHC NM, and ULIC NY, as reported in their respective annual statements for the years ended December 31, 2017 and 2016. A combined summary is as follows:

	2017	2016
Admitted assets	$ 4,488,253,524	$ 4,133,839,759
Total liabilities	2,352,545,359	2,213,130,975
Capital and surplus	2,135,708,164	1,920,708,784
Net income	516,803,658	543,059,025

The following table illustrates the fair value and gross unrealized holding losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrealized loss position, as of December 31, 2017 and 2016:

	2017					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
U.S. government and agency securities	$ 895,144,256	$ 5,947,462	$ 576,353,815	$ 15,901,835	$ 1,471,498,071	$ 21,849,297
State and agency municipalities	273,418,542	2,429,290	64,437,447	1,014,661	337,855,989	3,443,951
City and county municipalities	168,689,413	1,256,024	62,493,209	972,009	231,182,622	2,228,033
Corporate debt securities (includes commercial paper)	1,616,391,517	8,439,050	291,153,399	5,681,370	1,907,544,916	14,120,420
Other invested assets	2,646,255	36,968	53,916,576	22,088,268	56,562,831	22,125,236
Preferred stocks	1,727,993	103,211	-	-	1,727,993	103,211
Mutual funds	467,382	5,786	27,956,143	11,792,717	28,423,525	11,798,503
Unaffiliated common stocks	98,378,932	5,327,966	10,920,675	2,339,648	109,299,607	7,667,614
Total bonds, short-term investments, and equity (including marketable common stocks)	$ 3,056,864,290	$ 23,545,757	$ 1,087,231,264	$ 59,790,508	$ 4,144,095,554	$ 83,336,265

	2016					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses	Fair Value	Gross Unrealized Holding Losses
U.S. government and agency securities	$ 1,083,706,781	$ 23,919,559	$ 9,337,936	$ 382,545	$ 1,093,044,717	$ 24,302,104
State and agency municipal securities	346,724,762	7,584,963	-	-	346,724,762	7,584,963
City and county municipal securities	453,226,773	9,877,382	-	-	453,226,773	9,877,382
Corporate bonds (includes commercial paper)	1,446,211,010	17,134,419	130,167,362	3,543,189	1,576,378,372	20,677,608
Other invested assets	2,731,999	174,836	49,924,296	26,335,244	52,656,295	26,510,080
Preferred stocks	2,445,609	5,147	1,747,001	244,998	4,192,610	250,145
Mutual funds	1,218,441	59,489	25,811,215	14,057,205	27,029,656	14,116,694
Unaffiliated common stocks	96,323,033	7,099,300	10,658,358	1,029,458	106,981,391	8,128,758
Total bonds, short-term investments, and equity (including marketable common stocks)	$ 3,432,588,408	$ 65,855,095	$ 227,646,168	$ 45,592,639	$ 3,660,234,576	$ 111,447,734

The unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities at December 31, 2017 and 2016, were mainly caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company evaluated the credit ratings of the municipal, local agency, and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an OTTI, such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded OTTIs of $1,321,890 and $7,624,799 as of December 31, 2017 and 2016, respectively, which are included in net realized capital gains (excluding gains (losses) transferred to the IMR) less capital gains tax in the statutory basis statements of operations.

Net realized capital gains (excluding gains (losses) transferred to the IMR) less capital gains tax net of federal income taxes incurred and amounts transferred to the IMR as of December 31, 2017 and 2016, are as follows:

	2017	2016
Realized capital gains—net of related taxes of $23,017,607 and $23,015,244 in 2017 and 2016, respectively	$ 41,762,567	$ 41,664,659
Less amount transferred to IMR—net of related taxes of $4,264,180 and $15,340,377 in 2017 and 2016, respectively	7,919,191	28,489,270
Net realized capital gains—net of tax and amounts transferred to IMR	$ 33,843,376	$ 13,175,389

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTIs on loan-backed securities as of December 31, 2017.

As of December 31, 2016, the Company has classified loan-backed securities that have an OTTI as intent to sell. For the remaining loan-backed securities, the Company has the intent and ability to retain the investment in the security for a period of time sufficient to recover the amortized cost basis and determined that the present value of cash flows to be collected is equal to or exceeds the amortized cost basis of the security, as of December 31, 2016.

(3) The Company did not have any loan-backed securities with an OTTI to report by CUSIP as of December 31, 2017. The table below represents the loan-backed securities with an OTTI for the year ended December 31, 2016, presented by CUSIP:

		2016				
1	2	3	4	5	6	7
CUSIP	Book/Adjusted Carrying Value Amortized Cost before Current Period OTTI	Present Value of Projected Cash Flows	Recognized Other-than-Temporary Impairment	Amortized Cost After Other-than-Temporary Impairment	Fair Value at Time of OTTI	Date of Financial Statement Where Reported
07131RAA5	$ 6,237,674	$ 6,195,119	$ 42,554	$ 6,195,119	$ 6,195,119	3/31/2016
62405TAA5	5,453,044	5,407,694	45,351	5,407,694	5,407,694	3/31/2016
Total	XXX	XXX	$ 87,905	XXX	XXX	

(4) The following table illustrates the fair value, gross unrealized losses, and length of time that the loan-backed securities have been in a continuous unrealized loss position as of December 31, 2017 and 2016:

	2017
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 4,680,212
2. 12 months or longer	7,689,623
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	882,976,210
2. 12 months or longer	353,632,866

	2016
The aggregate amount of unrealized losses:	
1. Less than 12 months	13,975,025
2. 12 months or longer	1,986,101
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	971,303,507
2. 12 months or longer	93,014,043

The Company believes that it will collect all principal and interest due on all investments that have an amortized cost in excess of fair value. The unrealized losses as of December 31, 2017 and 2016 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities.

E. **Dollar Repurchase Agreements and/or Securities Lending Transactions**—Not applicable.

F. **Repurchase Agreements Transactions Accounted for as Secured Borrowing**—Not applicable.

G. **Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing**—Not applicable.

H. **Repurchase Agreements Transactions Accounted for as a Sale**—Not applicable.

I. **Reverse Repurchase Agreements Transactions Accounted for as a Sale**—Not applicable.

J. **Real Estate**—Not applicable.

K. **LIHTC**

(1–7) LIHTC investments of $148,269,382 and $106,725,645 as of December 31, 2017 and 2016, respectively, are included in other invested assets in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company also has a corresponding liability of $20,862,014 and $8,703,445 as of December 31, 2017 and 2016, respectively, which represents the future capital contributions that will be required as long as the asset is performing based on the agreed upon terms. The number of remaining years of unexpired tax credits is 9 years, and the required holding period for the LIHTC

investments is 14 years. The LIHTC investments are not currently subject to any regulatory reviews. The Company did not recognize any impairment losses, write-downs, or reclassifications during 2017 or 2016.

L. Restricted Assets—

(1) Restricted assets, including pledged securities as of December 31, 2017 and 2016, are presented below:

	Gross (Admitted & Nonadmitted) Restricted									Percentage	
	Current Year										
	1	2	3	4	5	6	7	8	9	10	11
Restricted Asset Category	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 Plus 3)	Total from Prior Year	Increase/ (Decrease) (5 Minus 6)	Total Nonadmitted Restricted	Total Admitted Restricted (5 minus 8)	Gross (Admitted & Nonadmitted) Restricted to Total Assets (c)	Admitted Restricted to Total Admitted Assets (d)
a Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
b Collateral held under security lending agreements	-	-	-	-	-	-	-	-	-		
c Subject to repurchase agreements	-	-	-	-	-	-	-	-	-		
d Subject to reverse repurchase agreements	-	-	-	-	-	-	-	-	-		
e Subject to dollar repurchase agreements	-	-	-	-	-	-	-	-	-		
f Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-	-	-		
g Placed under option contracts	-	-	-	-	-	-	-	-	-		
h Letter stock or securities restricted as to sale—excluding FHLB capital stock	-	-	-	-	-	-	-	-	-		
i FHLB capital stock	-	-	-	-	-	-	-	-	-		
j On deposit with states	2,012,411	-	-	-	2,012,411	2,429,115	(416,704)	-	2,012,411		
k On deposit with other regulatory bodies	-	-	-	-	-	-	-	-	-		
l Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-	-	-		
m Pledged as collateral not captured in other categories	-	-	-	-	-	-	-	-	-		
n Other restricted assets	-	-	-	-	-	-	-	-	-		
o Total restricted assets	$ 2,012,411	$ -	$ -	$ -	$ 2,012,411	$ 2,429,115	$ (416,704)	$ -	$ 2,012,411	-	% -

(a) Subset of column 1
(b) Subset of column 3
(c) Column 5 divided by Asset Page, Column 1, Line 28
(d) Column 9 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2017 or 2016.

M. Working Capital Finance Investments—Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. Structured Notes

The Company does not have any structured notes.

P. 5* Securities

The Company does not have any investments with an NAIC designation of 5* as of December 31, 2017 and 2016.

Q. **Short Sales**—Not applicable.

R. **Prepayment Penalty and Acceleration Fees**—Not applicable.

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

B. There were no investment income amounts excluded from the statutory basis financial statements.

8. DERIVATIVE INSTRUMENTS

A–H. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2017 and 2016, are as follows:

	2017			2016			Change		
	1	2	3 (Col 1 + 2)	4	5	6 (Col 4 + 5)	7 (Col 1 - 4)	8 (Col 2 - 5)	9 (Col 7 + 8)
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
(a) Gross deferred tax assets	$ 364,888,191	$ 1,620,351	$ 366,508,542	$ 546,724,093	$ 2,318,288	$ 549,042,382	$ (182,035,902)	$ (697,938)	$ (182,733,840)
(b) Statutory valuation allowance adjustments	-	131,049	131,049	-	1,074,223	1,074,223	-	(943,174)	(943,174)
(c) Adjusted gross deferred tax assets (1a - 1b)	364,888,191	1,489,302	366,187,493	546,724,093	1,244,066	547,968,159	(182,035,902)	245,236	(181,784,666)
(d) Deferred tax assets nonadmitted	-	-	-	23,580,643	-	23,580,643	(23,580,643)	-	(23,580,643)
(e) Subtotal net admitted deferred tax asset (1c - 1d)	364,888,191	1,489,302	366,187,493	523,131,350	1,244,066	524,378,416	(158,455,259)	245,236	(158,210,023)
(f) Deferred tax liabilities	86,773,498	1,013,017	87,786,515	64,971,912	562,629	65,534,540	21,801,586	450,388	22,251,975
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 277,924,693	$ 476,285	$ 278,400,978	$ 458,159,438	$ 681,437	$ 458,843,876	$ (180,256,845)	$ (205,152)	$ (180,461,998)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, *Income Taxes—A Replacement of SSAP No. 10R and SSAP No. 10*, are as follows:

	2017			2016			Change		
	1	2	3	4	5	6	7	8	9
Admission Calculation Components SSAP No. 101	**Ordinary**	**Capital**	**(Col 1 + 2) Total**	**Ordinary**	**Capital**	**(Col 4 + 5) Total**	**(Col 1 - 4) Ordinary**	**(Col 2 - 5) Capital**	**(Col 7 + 8) Total**
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 364,698,191	$ 1,489,302	$ 366,187,493	$ 433,621,469	$ 1,244,066	$ 434,865,535	$ (68,923,278)	$ 245,236	$ (68,678,042)
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)			-	23,978,336	-	23,978,336	(23,978,336)	-	(23,978,336)
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	23,978,336	-	23,978,336	(23,978,336)	-	(23,978,336)
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	975,868,396	XXX	XXX	767,081,754	XXX	XXX	208,906,642
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	65,534,545	-	65,534,545	(65,534,545)	-	(65,534,545)
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 364,698,191	$ 1,489,302	$ 366,187,493	$ 523,134,350	$ 1,244,066	$ 524,378,416	$ (158,436,159)	$ 245,236	$ (158,190,923)

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2017	2016
(a) Ratio percentage used to determine recovery period and threshold limitation amount	453 %	441 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 6,506,589,304	$ 5,113,878,359

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2017 and 2016, is presented below:

	2017		2016		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	**Ordinary**	**Capital**	**Ordinary**	**Capital**	**(Col 1 - 3) Ordinary**	**(Col 2 - 4) Capital**
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 364,698,191	$ 1,489,302	$ 546,724,993	$ 1,244,066	$ (182,026,802)	$ 245,236
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 364,698,191	$ 1,489,302	$ 523,134,350	$ 1,244,066	$ (158,436,159)	$ 245,236
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2017 and 2016.

C. Significant Components of Income Taxes

(1) The current federal and foreign income taxes incurred for the years ended December 31, 2017 and 2016 are as follows:

	1 2017	2 2016	3 (Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 1,130,820,262	$ 875,233,668	$ 255,586,594
(b) Foreign	-	-	-
(c) Subtotal	1,130,820,262	875,233,668	255,586,594
(d) Federal income tax on net capital gains	23,017,607	23,015,244	2,363
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 1,153,837,869	$ 898,248,912	$ 255,588,957

(2–4) The tax effect of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2017 and 2016, are as follows:

	1 2017	2 2016	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 106,419,200	$ 224,170,529	$ (117,751,329)
(2) Unearned premium reserve	28,485,521	42,100,135	(13,614,614)
(3) Policyholder reserves	-	-	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	109,179,442	166,769,840	(57,590,398)
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	635,349	-	635,349
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables—nonadmitted	67,300,344	102,162,971	(34,862,627)
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carry forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	52,678,335	11,521,518	41,156,817
(99) Subtotal	364,698,191	546,724,993	(182,026,802)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	23,590,643	(23,590,643)
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	364,698,191	523,134,350	(158,436,159)
(e) Capital:			
(1) Investments	1,620,351	2,318,289	(697,938)
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	1,620,351	2,318,289	(697,938)
(f) Statutory valuation allowance adjustment	131,049	1,074,223	(943,174)
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	1,489,302	1,244,066	245,236
(i) Admitted deferred tax assets (2d + 2h)	366,187,493	524,378,416	(158,190,923)
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	1,380,886	1,791,330	(410,444)
(2) Fixed assets	-	1,135,286	(1,135,286)
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	85,392,612	62,045,301	23,347,311
(99) Subtotal	86,773,498	64,971,917	21,801,581
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities	1,013,017	562,629	450,388
(99) Subtotal	1,013,017	562,629	450,388
(c) Deferred tax liabilities (3a99 + 3b99)	87,786,515	65,534,546	22,251,969
4 Net deferred tax assets/liabilities (2i - 3c)	$ 278,400,978	$ 458,843,870	$ (180,442,892)

The other ordinary deferred tax asset of $52,678,335 for 2017 consists of partnership investments of $50,556,040 and general expenses due and accrued of $2,122,295. The other ordinary deferred tax asset of $11,521,518 for 2016 consists of general expenses due and accrued of $11,482,663 and tax intangibles of $38,855.

The other ordinary deferred tax liability of $85,392,612 for 2017 consists of partnership investments of $53,433,006, guaranty fund assessments of $28,974,959, premium acquisition expense of $2,768,607, and bad debt of $216,040. The other ordinary deferred tax liability of $62,045,301 for 2016 consists of prepaid expenses of $40,301,887, partnership investments of $12,080,424, premium acquisition expense of $5,779,387, guaranty fund assessments of $2,373,417, bad debt of $848,299, and discounting of unpaid losses of $661,887.

The other capital deferred tax liability of $1,013,017 for 2017 and $562,629 for 2016 consists of unrealized losses.

On December 22, 2017, the U.S. federal government enacted a tax bill, H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 ("Tax Reform"). Tax Reform changed existing United States tax law including a reduction of the U.S. corporate tax rate. The Company has accounted for the impacts of Tax Reform by remeasuring its deferred tax assets/(liabilities) at the 21% enacted tax rate. The impact of the change in tax rate was a decrease in net deferred tax assets/(liabilities) of $185,600,652. This change is made up of the following components:

Change in net deferred income tax	$ 186,363,363
Change in net unrealized capital gains less capital gains tax	(675,345)
Change in statutory valuation allowance adjustment	(87,366)
Total	$ 185,600,652

The Company's deferred tax assets/(liabilities) for the year ended December 31, 2016 remain at the previously enacted tax rate. The Company's measurement of the income tax effects of Tax Reform for the year ended December 31, 2017 is reasonably estimated.

The Company assessed the potential realization of the gross deferred tax asset and established a valuation allowance of $131,049 and $1,074,223 to reduce the gross deferred tax asset to $366,187,493 and $547,969,059 as of December 31, 2017 and 2016, respectively, which represents the amount of the asset estimated to be recoverable via carryback of losses and reduction of future taxes. The change in the valuation allowance is attributable to the change in timing of deductibility of expenses and/or expectations for future taxable income.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 35% to net income before federal income taxes incurred, plus capital gains tax. A summarization of the significant items causing this difference as of December 31, 2017 and 2016 is as follows:

	2017		2016	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$1,293,797,716	35 %	$975,347,293	35 %
Capital gains	22,673,061	1	22,637,966	1
Total income tax	1,316,470,777	36	997,985,259	36
Tax-exempt interest	(10,261,371)	-	(9,999,737)	-
Health insurer fee	-	-	183,701,571	7
Current year tax credit	(19,153,041)	(1)	(20,410,985)	(1)
Other current year items	8,903,175	-	(14,642,864)	(1)
Tax effect of nonadmitted assets	(10,839,710)	-	(14,363,776)	(1)
Prior year true-up	187,011	-	-	-
Subsidiary dividends	(107,380,000)	(3)	(228,970,000)	(8)
Change in deferred taxes due to change in tax rate	186,363,363	5	-	-
Change in statutory valuation allowance	(943,174)	-	(5,113,485)	-
Other	(5,926,014)	-	(3,826,587)	-
Total statutory income taxes	1,357,421,016	37 %	884,359,396	32 %
Federal income taxes incurred	$1,130,820,262	31 %	$875,233,668	31 %
Capital gains tax	23,017,607	1	23,015,244	1
Change in net deferred income tax	203,583,147	5	(13,889,516)	-
Total statutory income taxes	$1,357,421,016	37 %	$884,359,396	32 %

E. At December 31, 2017, the Company had no net operating loss carryforwards.

Current federal income taxes (payable) recoverable of $(133,220,235) and $157,896,371 as of December 31, 2017 and 2016, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $897,049,897 and $1,090,547,384 in 2017 and 2016, respectively.

Federal income taxes incurred of $1,246,848,914 and $851,532,898 for 2017 and 2016, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 ("Deposits made to suspend running of interest on potential underpayments, etc.") of the Internal Revenue Service ("IRS") Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in the NAIC Statutory Statement Schedule Y - Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group

pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The IRS has completed exams on UnitedHealth Group's consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group's 2017 tax return is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to 2011 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. **Tax Contingencies**—Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–N. Material Related Party Transactions

Pursuant to the terms of the Agreement, UHS will provide management services to the Company under a fee structure, which is based on a percentage of premium charges representing UHS' expenses for services or use of assets provided to the Company. In addition, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a PMPM basis (where the charges incurred by UHS is on a PMPM basis) or using another allocation methodology consistent with the Agreement. These services may include, but are not limited to, integrated personal health management solutions, such as disease management, treatment decision support, and wellness services, including a 24-hour call-in service, access to a network of transplant providers, and discount program services. The amount and types of services provided pursuant to the pass-through provision of the Agreement can change year over year as UHS becomes the contracting entity for services provided to the Company's members. Total administrative services, capitation, and access fees under this arrangement totaled $3,759,293,331 and $3,071,057,905 in 2017 and 2016, respectively, and are included in benefits under life and accident and health insurance contracts—net and general insurance expenses in the statutory basis statements of operations. Direct expenses not covered under the Agreement, such as broker commissions, DOI exam fees, ACA assessments, and premium taxes, are paid by UHS on behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

The Company also directly contracts with related parties to provide services to its members. The Company expensed as benefits under life and accident and health insurance contracts—net and general insurance expenses $1,286,447,161 and $1,484,712,657 in capitation expenses, administrative services, and access fees paid to related parties during 2017 and 2016, respectively. OptumHealth Care Solutions, Inc. provides chiropractic, physical therapy and complex medical conditions services. Spectera, Inc. provides administrative services related to vision benefit management and claims processing. Dental Benefit Providers, Inc. provides dental care assistance. United Behavioral Health provides mental health and substance abuse services. UnitedHealthcare Specialty Benefits, LLC. provides financial protection services. LifePrint provides complex medical conditions services.

The capitation expenses, administrative services, and access fees paid to related parties that are included in benefits under life and accident and health insurance contracts—net and general insurance expenses in the statutory basis statements of operations for the years ended December 31, 2017 and 2016, are shown below:

	2017	2016
LifePrint	$ 830,260,014	$ 1,089,816,652
United Behavioral Health	380,541,554	327,889,877
OptumHealth Care Solutions, Inc.	60,995,891	55,869,205
Dental Benefit Providers, Inc.	9,024,844	6,565,437
Spectera, Inc.	5,609,332	4,560,727
UnitedHealthcare Specialty Benefits, LLC	15,526	10,759
Total	$ 1,286,447,161	$ 1,484,712,657

Management believes that its transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

The Company contracts with OptumRx to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees. Fees related to these agreements, which are calculated on a per-claim basis, of $502,133,268 and $479,143,343 in 2017 and 2016, respectively, are included in general insurance expenses in the statutory basis statements of operations.

The Company contracts with OptumRx to provide personal health products catalogues showing the healthcare products and benefit credits needed to redeem the respective products. OptumRx will mail the appropriate personal health products catalogues to the Company's members and manage the personal health products credit balance. OptumRx also distributes personal health products to individual members based upon the terms of the agreement. Fees related to these agreements in 2017 and 2016, which are calculated on a PMPM basis, of $76,035,495 and $19,527,316, respectively, are included in benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations.

The Company contracts with OptumRx to provide durable medical equipment services and/or orthotics and prosthetics to the Company's members. Fees related to these agreements in 2017 and 2016, which are calculated on a per-claim basis, of $1,693,159 and $0, respectively, are included in benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations.

The Company has an agreement with OptumInsight, Inc., an affiliate of the Company, for claim analytics, recovery of medical expense overpayments, retroactive fraud, waste, and abuse, subrogation, and premium audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis and a capitated service fee is charged to the Company as a PMPM. Fees of $83,869,516 and $69,599,168 are included in benefits under life and accident and health insurance contracts—net and general insurance expenses in the statutory basis statements of operations for the years ended December 31, 2017 and 2016, respectively.

The Company has premium payments that are received and claim payments that are processed by an affiliated UnitedHealth Group entity. Both premiums and claims applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in payable to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has an agreement with AxelaCare Intermediate Holding, LLC, an affiliate of the Company, for home infusion therapy services. This agreement has been approved by the Department. The charges incurred for these services are included in benefits under life and accident and health insurance contracts—net in the statutory basis financial statements for the years ended December 31, 2017 and 2016.

Effective April 1, 2016, the Company has an administrative services only agreement with OrthoNet, LLC, ("OrthoNet"), an affiliate of the Company, to provide utilization management and related management services for certain musculoskeletal procedures. These administrative services include but are not limited to prior authorization, medical management, claims, appeals, and grievances. OrthoNet is paid a PMPM for the administrative services and the Company is responsible for the cost of medical services.

The Company has a quota share reinsurance agreement with UHIC NY, a wholly owned subsidiary of the Company (see Note 1). Premiums of $1,778,241,908 and $1,663,005,766 were assumed by the Company for the years ended December 31, 2017 and 2016, respectively, and assumed premium receivables due from UHIC NY were $166,321,775 and $191,940,106 as of December 31, 2017 and 2016, respectively. Incurred insurance benefits related to the quota share reinsurance agreement were $1,465,489,599 and $1,317,608,361 for the years ended December 31, 2017 and 2016, respectively, and the Company had assumed claims payable relating to this reinsurance agreement of $234,454,690 and $222,022,440 as of December 31, 2017 and 2016, respectively. General insurance expenses and CAE of $248,200,460 and $249,723,769 were assumed by the Company for the years ended December 31, 2017 and 2016, respectively, and the Company had a liability for assumed general insurance expenses and CAE relating to this agreement of $18,031,633 and $30,972,315 as of December 31, 2017 and 2016, respectively. The funds withheld amounts due from UHIC NY were $46,868,391 and $45,179,012 as of December 31, 2017 and 2016, respectively, and are included in reinsurance in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has a quota share reinsurance agreement with UnitedHealthcare of the Midwest ("Midwest"), an affiliate of the Company. Per this agreement, the Company assumes 60% quota share reinsurance of Midwest's net liability under policies, contracts, and binders of insurance or reinsurance assumed, excluding its Medicare business. Premiums of $792,554,951 and $614,499,852 were assumed by the Company for the years ended December 31, 2017 and 2016, respectively, and assumed premium receivables due from Midwest were $79,309,634 and $49,285,781 as of December 31, 2017 and 2016, respectively. Incurred insurance benefits related to the quota share reinsurance agreement were $701,382,963 and $509,214,856 for the years ended December 31, 2017 and 2016, respectively, and the Company had assumed claims payable relating to this reinsurance agreement of $135,588,499 and $79,391,435 as of December 31, 2017 and 2016, respectively. General insurance expenses of $94,268,381 and $81,440,295 were assumed by the Company for the years ended December 31, 2017 and 2016, respectively, and the Company had a liability for assumed expenses relating to this agreement of $9,799,234 and $8,158,276 as of December 31, 2017 and 2016, respectively.

The Company has a reinsurance agreement with Unimerica Insurance Company, Inc., an affiliate of the Company, to cede obligations relating to chiropractic and physical therapy coverage, and mental health and substance use disorder coverage. Ceded reinsurance premiums, which are calculated on a PMPM basis, were $109,269,172 and $104,656,505 as of December 31, 2017 and 2016, respectively, and were netted against premiums for life and accident and health contracts—net in the statutory basis statements of operations. Reinsurance recoveries of $99,542,920 and $93,786,078 as of December 31, 2017 and 2016, respectively are included in benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations. Reinsurance contracts do not relieve the Company from its obligations to policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company. This agreement was terminated effective December 31, 2017.

The Company holds a $1,000,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. The aggregate principal amount that may be outstanding at any time is the lesser of 3% of the Company's admitted assets or 25% of the Company's policyholder surplus as of the preceding December 31. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective June 1, 2017. No amounts were outstanding under the line of credit as of December 31, 2017 and 2016.

At December 31, 2017 and 2016, the Company reported $848,382,660 and $718,785,636, respectively, as payable to parent, subsidiaries, and affiliates, net, which are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

In addition to the agreements above, UHS maintains a private short-term investment pool in which affiliated companies may participate (see Note 1). At December 31, 2017 and 2016, the Company's portion was $1,713,344,414 and $991,648,849, respectively, and is included in short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company has entered into a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

Cash dividends from wholly owned subsidiaries totaled $306,800,000 and $594,200,000 for the years ended December 31, 2017 and 2016, respectively, and are included in net investment income in the statutory basis statements of operations. In addition, in 2016, the Company received a non-cash dividend from UnitedHealthcare Service LLC ("UHS LLC"), an affiliate, of $60,000,000, in the form of a receivable from UHS, which was fully non-admitted as of December 31, 2016. No non-cash dividends were received in 2017. On December 20, 2017, the Company distributed this receivable as a non-cash dividend of $60,000,000 to UHIC. The dividend complied with the provisions set forth in the statutes of Connecticut. The dividend was recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

On March 29, 2016, the Company purchased home office real estate from UHS at a fair value of $291,282,369, which is reported as real estate properties occupied by the Company in the statutory basis statements of admitted assets, liabilities, and capital and surplus. In addition, effective March 29, 2016 the Company entered into a long-term lease agreement with UHS, which provides for an initial lease term of 20 years, with annual rent escalation in each year through year 15, and 4 extension options of 5 years each. The Company has recorded rental income for the occupancy of its own building in the amount of $17,854,590 and $13,222,385 for the years ended December 31, 2017 and 2016, respectively, which is included in net investment income in the statutory basis statements of operations (see Note 1).

Effective January 1, 2017, the Company transferred the real estate at book value to EP Campus, a wholly owned subsidiary of the Company (See Note 1). Effective October 16, 2017, 5995 Minnetonka, a wholly owned subsidiary of the Company purchased real estate from an unaffiliated seller (See Note 1). Pursuant to SSAP 40R, the Company reports the real estate owned by EP Campus and 5995 Minnetonka as properties occupied by the Company in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company paid dividends of $1,770,000,000 and $2,175,000,000 in 2017 and 2016, respectively, to its parent (see Note 13).

The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary or controlled or affiliated entity.

The Company does not have any investments in a subsidiary or controlled or affiliated entity that exceeds 10% of admitted assets.

The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in foreign insurance subsidiaries.

The Company does not hold any investments in a downstream noninsurance holding company.

The Company has investments in non-insurance subsidiaries, controlled, or affiliated entities.

The Company has investments in insurance subsidiaries, controlled, or affiliated entities.

The Company provides a commitment to the New York State Department of Financial that the premium-to-surplus ratio for its wholly owned subsidiary, UHIC NY, is not more than four-to-one.

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party other than as disclosed above.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2017 and 2016.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES, AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, SHAREHOLDERS' DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

(1–2) The Company has 1,000 shares authorized and 500 shares issued and outstanding of $6,000 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHIC.

(3) Payment of dividends may be restricted by Connecticut insurance regulations. The Insurance Commissioner may disapprove any dividend that, together with other dividends paid by the Company in the prior 12 months, exceeds the greater of the following:

a. 10% of the statutory capital and surplus as of the preceding December 31, or

b. The net income from operations for the calendar year preceding the date of the dividend or distribution.

(4) The company distributed the following dividends in 2017:

- $480,000,000 ordinary cash dividend declared on March 7, 2017 and paid on March 24, 2017 to the sole shareholder, UHIC.
- $750,000,000 ordinary cash dividend declared on June 14, 2017 and paid on June 27, 2017 to UHIC.
- $480,000,000 ordinary cash dividend declared on September 14, 2017 and paid on September 26, 2017 to UHIC.
- $60,000,000 non-cash dividend declared on December 8, 2017 and distributed on December 20, 2017 to UHIC (See Note 10).

The above dividends complied with the provisions set forth in the statutes of Connecticut. The dividends were recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company received a cash infusion of $180,500,000 on December 29, 2017, from UHIC, which was recorded as an increase to gross paid-in and contributed surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

(5) The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

(6) There are no restrictions placed on the Company's unassigned surplus.

(7) The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

(8) The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

(9) For the year ended December 31, 2017, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned surplus was $807,056,895. As discussed in Note 1, in 2016 no amount was required to be apportioned out of unassigned surplus for the Section 9010 ACA subsequent fee year assessment.

(10) The portion of unassigned surplus, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividends or infusions, represented (or reduced) by each item below is as follows:

	2017	2016	Change
Unrealized capital gains on investments less capital gains tax	$757,542,816	$530,357,092	$227,185,724
Net deferred income taxes	280,249,584	483,832,731	(203,583,147)
Nonadmitted assets	(324,735,518)	(377,355,561)	52,620,043
Asset valuation reserve	(479,703,019)	(372,209,589)	(107,493,430)
Total	$233,353,863	$264,624,673	$ (31,270,810)

(11–13) The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

(1) A liability for guaranty fund assessments is accrued after the insolvency has occurred. A liability for other assessments is accrued based upon historical trends. A liability for guaranty fund and other assessments of $216,974,648 and $558,181,224 and an asset for related premium tax offsets of $137,975,995 and $115,148,248 are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2017 and 2016, respectively. The Company incurred assessment (benefit) expense of $(95,319,863) and $586,319,088 for 2017 and 2016, respectively, which are included in Insurance TL&F in the statutory basis statements of operations. The Company takes credits on its premium tax returns based upon pre-determined guidance from the assessing state.

(2) Assets recognized from paid and accrued premium tax offsets and policy surcharges are presented below:

a. Assets recognized from paid and accrued premium tax offsets and policy surcharges prior year-end	$115,148,248
b. Decreases current year:	-
c. Increases current year: Premium tax offset applied	22,827,747
d. Assets recognized from paid and accrued premium tax offsets and policy surcharges current year-end	$137,975,995

(3) Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. In 2009, the Pennsylvania Insurance Commissioner placed long term care insurer Penn Treaty Network America Insurance Company and its subsidiary ("Penn Treaty"), neither of which is affiliated with the Company, in rehabilitation and petitioned the Commonwealth of Pennsylvania Court ("the Commonwealth Court") for approval to liquidate Penn Treaty. In 2012, the Commonwealth Court denied the liquidation petition and ordered the Insurance Commissioner to submit a rehabilitation plan. Plans for rehabilitation were subsequently not approved by the Commonwealth Court. In November 2016, the Commonwealth Court approved the request for liquidation orders with findings of insolvency. On March 1, 2017, the Commonwealth Court entered the written liquidation orders.

As of December 31, 2016, the Company recorded an undiscounted liability of $568,834,862 for its estimated share of the guaranty association assessment liability resulting from the Penn Treaty liquidation. Pursuant to the adoption of the revised accounting and disclosure requirements of SSAP No. 35R (see Note 1), as of March 31, 2017, the Company recorded $428,177,885 and $152,193,448 for its estimated share of the discounted guaranty association assessment liability and associated premium tax credit

asset resulting from the Penn Treaty liquidation, which is included in taxes, licenses and fees due or accrued, excluding federal income taxes and other assets, respectively, in the statutory basis financial statements. The net difference between the undiscounted and discounted amounts established for the guaranty association assessment liability and associated premium tax credit asset, net of current federal income tax, is $104,178,921 of which $125,946,628 is included as a change in accounting principle, net of tax, and deferred tax expense of $21,767,707 is included in change in deferred income tax in the statutory basis statements of changes in capital and surplus (see Note 2). Subsequent to March 31, 2017, the Company revised its liability largely due to estimated payments made for the Penn Treaty insolvency guaranty assessments. While the ultimate payment timing and associated recovery is currently unknown, the Company anticipates that the majority of the assessments will be paid within the next five years.

Assessments from insolvencies is presented below:

a. Discount Rate Applied 3.5 %

b. The Undiscounted and Discounted Amount of the Guaranty Fund Assessments and Related Assets by Insolvency:

	Guaranty Fund Assessment		Related Assets	
Name of the Insolvency	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty	$ 237,372,264	$ 153,752,632	$ 170,238,158	$ 130,088,699

c. Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency:

	Payables			Recoverables		
Name of the Insolvency	Number of Jurisdictions	Range of Years	Weighted Average of Number of Years	Number of Jurisdictions	Range of Years	Weighted Average of Number of Years
Penn Treaty	39	1–22	10.79	40	5–41	16.65

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the statutory basis financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits—Not applicable.

E. Joint and Several Liabilities—Not applicable.

F. All Other Contingencies

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

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

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

On February 14, 2017, the Department of Justice ("DOJ") announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company, along with a number of other Medicare Advantage plans, made improper risk adjustment submissions and violated the False Claims Act. On March 24, 2017, the DOJ intervened in a separate lawsuit initially asserted against the Company and filed by a whistleblower in 2009 concerning risk adjustment submissions by Medicare Advantage plans. On October 5, 2017, in one of the cases, the district court dismissed certain of the DOJ's claims with prejudice, and dismissed all of the DOJ's remaining claims with leave to file a further amended complaint. On October 12, 2017, the DOJ filed a notice of dismissal without prejudice of the case. In the remaining case, on February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. The Company cannot reasonably estimate the outcome that may result from these matters given their current posture.

Risk Adjustment Data Validation ("RADV") Audit—CMS adjusts capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers. The Company collects claim and encounter data from providers who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

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

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

As of November 2013, CMS informed the Company that it had been selected for a RADV audit for the 2011 payment year. This audit closed in May 2015 and no information has been received from CMS regarding results or when to expect results. As a result, the Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations,

audits, and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines, and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

In September 2015, CMS informed the Company that it had been selected for a RADV audit for 2011 dates of service (2012 payment year). This audit closed in May 2016 and no information has been received from CMS regarding results or when to expect results. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines, and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers, and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties, or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances, and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no assets that the Company considers to be impaired at December 31, 2017 and 2016, except as disclosed in Note 5 and Note 20.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A. On June 30, 2017, the Company sold a premium receivable, and related accrued interest, at face value to an unaffiliated third party. The Company received $119,187,119 for the premiums receivable and an additional $8,445,454 for the accrued interest receivable. There was no gain or loss recorded on this sale. The Company did not have any transfers of receivables reported as sales as of December 31, 2016.

B. The Company did not have any transfer and servicing of financial assets as of December 31, 2017 or December 31, 2016.

C. The Company did not participate in any wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A. Administrative Services Only ("ASO") Plans

The company provides certain claims and other administrative services for its uninsured customers through ASO contracts. The total net gain from operations as a result of reimbursement for administrative fees in excess of actual expenses during 2017 and 2016 was $33,072,092 and $32,376,445, respectively. These items are included in general insurance expenses in the accompanying statutory basis statements of operations. The related claims payment volume administered by the company on behalf of its ASO customers was $1,198,773,281 and $1,030,739,222 for 2017 and 2016, respectively.

B. The Company has no operations from Administrative Services Contracts.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a payable in liability for amounts held under uninsured plans of $217,120,186 at December 31, 2017, and a receivable in amounts receivable relating to uninsured plans of $252,990,794 at December 31, 2016, both in the statutory basis statements of admitted assets, liabilities, and capital and surplus, for cost reimbursement under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies as described in Note 1, *Amounts Receivable Relating to Uninsured Plans* and *Liability for Amounts Held Under Uninsured Plans.* The Company also recorded a receivable of $245,921,160 and $322,831,086 and also a payable of $192,470,240 and $160,410,327 at December 31, 2017 and 2016, respectively, for the Medicare Part D CGDP as described in Note 1, *Amounts Receivable Relating to Uninsured Plans* and *Liability for Amounts Held Under Uninsured Plans*.

The Company receives payments from CMS under the ACA CSR program designed to reduce copayments, deductibles, and coinsurance for lower-income members. There is no insurance risk to the Company as a result of the CSR program. Overpayments from CMS are reported in liability for amounts held under uninsured plans and underpayments are reported in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has recorded a liability of $107,746 and $6,288,547 for the CSR program as of December 31, 2017 and December 31, 2016, respectively.

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2017 and 2016.

20. FAIR VALUE MEASUREMENT

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1—Quoted (unadjusted) prices for identical assets in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3—Unobservable inputs that cannot be corroborated by observable market data.

Money-market funds activity is now included as a component of cash equivalents in 2017, whereas in 2016, money-market funds activity was included as a component of short-term investments. The amounts in the following disclosures and corresponding tables reflect this change in presentation. The Company's share of the investment pool sponsored and administered by UHS (see Note 1) is classified as a short-term investment. For presentation purposes, in 2016 the Company's share of the investment pool was reported in money-market funds whereas in 2017, the balance is reported in corporate debt securities.

The estimated fair values of bonds, short-term investments, preferred stocks, other invested assets, and common stocks are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service ("pricing service"), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following table presents information about the Company's financial assets that are measured and reported at fair value at December 31, 2017 and December 31, 2016 in the statutory basis statements of admitted assets, liabilities, and capital and surplus according to the valuation techniques the Company used to determine their fair values:

Description for Each Class of Asset or Liability	December 31, 2017 (Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair value:				
Perpetual preferred stock:				
Industrial and misc	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-
Total perpetual preferred stocks	-	-	-	-
Bonds:				
U.S. governments	-	-	-	-
Industrial and misc	-	353,438	-	353,438
Hybrid securities	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-
Total bonds	-	353,438	-	353,438
Common stock:				
Industrial and misc	414,364,722	-	-	414,364,722
Parent, subsidiaries, and affiliates	-	-	-	-
Total common stock	414,364,722	-	-	414,364,722
Derivative assets:				
Interest rate contracts	-	-	-	-
Foreign exchange contracts	-	-	-	-
Credit contracts	-	-	-	-
Commodity futures contracts	-	-	-	-
Commodity forward contracts	-	-	-	-
Total derivatives	-	-	-	-
Other invested assets	-	-	62,745,518	62,745,518
Separate account assets	-	-	-	-
Total assets at fair value	$ 414,364,722	$ 353,438	$ 62,745,518	$ 477,463,678
b. Liabilities at fair value:				
Derivative liabilities	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2016 (Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair value:				
Perpetual preferred stock:				
Industrial and misc	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-
Total perpetual preferred stocks	-	-	-	-
Bonds:				
U.S. governments	-	-	-	-
Industrial and misc	-	-	-	-
Hybrid securities	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-
Total bonds	-	-	-	-
Common stock:				
Industrial and misc	345,801,423	-	-	345,801,423
Parent, subsidiaries, and affiliates	-	-	-	-
Total common stock	345,801,423	-	-	345,801,423
Derivative assets:				
Interest rate contracts	-	-	-	-
Foreign exchange contracts	-	-	-	-
Credit contracts	-	-	-	-
Commodity futures contracts	-	-	-	-
Commodity forward contracts	-	-	-	-
Total derivatives	-	-	-	-
Other invested assets	-	-	54,011,756	54,011,756
Separate account assets	-	-	-	-
Total assets at fair value	$ 345,801,423	$ -	$ 54,011,756	$ 399,813,179
b. Liabilities at fair value:				
Derivative liabilities	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -

The Company considers its investments in LIHTC investments and certified capital company ("CAPCO") investments as a Level 3 investment even though no market valuation was required as of December 31, 2017 and 2016. As a result, these investments are excluded from being presented as a Level 3 security in the fair value hierarchy tables above. As there is no readily available market, these securities are recorded at book/adjusted carrying value and considered held to maturity as they will not be sold.

There were no transfers between Levels 1 and 2 during the years ended December 31, 2017 and 2016.

(2) Fair value measurements included in Level 3 of the fair value hierarchy table above at December 31, 2017 and December 31, 2016, are presented in the table below:

Description	Beginning Balance at 1/1/2017	Transfers Into Level 3	Transfers Out of Level 3	2017 Total Gains and (Losses) Included in Net Income	2017 Total Gains and (Losses) Included in Surplus	Purchases	Issuances	Sales	Settlements	Ending Balance at 12/31/2017
a Assets										
Loan-backed and structured securities (NAIC 3-6)										
Residential mortgaged-backed securities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial mortgaged-backed securities	-	-	-	-	-	-	-	-	-	-
Derivative:										
Credit contracts	-	-	-	-	-	-	-	-	-	-
Other fund investments										
Hedge fund high-yield debt securities	-	-	-	-	-	-	-	-	-	-
Private equity	-	-	-	-	-	-	-	-	-	-
Other Invested Assets	54,011,756	-	-	4,095,545	4,638,217	-	-	-	-	62,745,518
Total assets	$ 54,011,756	$ -	$ -	$ 4,095,545	$ 4,638,217	$ -	$ -	$ -	$ -	$ 62,745,518
b Liabilities										
None	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total liabilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Description	Beginning Balance at 1/1/2016	Transfers Into Level 3	Transfers Out of Level 3	2016 Total Gains and (Losses) Included in Net Income	2016 Total Gains and (Losses) Included in Surplus	Purchases	Issuances	Sales	Settlements	Ending Balance at 12/31/2016
a Assets										
Loan-backed and structured securities (NAIC 3-6)										
Residential mortgaged-backed securities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Commercial mortgaged-backed securities	-	-	-	-	-	-	-	-	-	-
Derivative:										
Credit contracts	-	-	-	-	-	-	-	-	-	-
Other fund investments										
Hedge fund high-yield debt securities	-	-	-	-	-	-	-	-	-	-
Private equity	-	-	-	-	-	-	-	-	-	-
Other Invested Assets	51,471,819	-	-	3,293,088	(753,151)	-	-	-	-	54,011,756
Total assets	$ 51,471,819	$ -	$ -	$ 3,293,088	$ (753,151)	$ -	$ -	$ -	$ -	$ 54,011,756
b Liabilities										
None	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total liabilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2017 or 2016.

(4) **Investments**—Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a pricing service, which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market

indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

LIHTC and CAPCO Investments—The Company does consider its investments in LIHTC investments and CAPCO investments as a Level 3 investment even though no market valuation adjustment was required as of December 31, 2017 and 2016, as a result these investments are excluded from being presented as a level 3 security in the financial hierarchy tables above. As there is no readily available market, these securities are recorded and reported at book/adjusted carrying value and considered held to maturity as they will not be sold. Should any contractual breakage occur that jeopardizes the ability to receive the tax credits associated with these securities, impairments will be recognized. As of December 31, 2017, all of these investments are performing in accordance with their original contract terms.

Private-Placement fixed-income securities—Private placement securities are by their nature illiquid securities as they can be sold only under an exemption from registration under federal securities laws. There is not an active public market for trading in these securities and pricing services generally do not offer prices for these securities. Also obtaining broker quotes for these security types is not feasible for those reasons. The Company purchases private placements with the intention of holding these securities until maturity.

The Company is responsible for the valuations assigned. The Company utilizes the expertise of its investment manager to assist in the valuation of these securities. All valuations are approved by the valuation committee of the investment manager and reviewed by UnitedHealth Group's investment management area.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination—Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2017 and 2016 is presented in the table below:

	2017					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 1,883,605,655	$ 1,901,490,098	$ 908,396,817	$ 975,208,838	$ -	$ -
State and agency municipal securities	844,157,713	833,115,229	-	844,157,713	-	-
City and county municipal securities	912,666,911	895,341,983	-	912,666,911	-	-
Corporate debt securities (includes commercial paper)	6,357,875,567	6,318,052,732	1,713,344,414	4,513,102,280	131,428,873	-
Other invested assets	211,014,900	211,014,900	-	-	211,014,900	-
Mutual funds	32,133,012	32,133,012	32,133,012	-	-	-
Unaffiliated common stock	380,906,141	380,906,141	380,906,141	-	-	-
Preferred stock	17,496,214	15,482,256	-	17,496,214	-	-
Total bonds, short-term investments, mutual funds, unaffiliated common stock, preferred stock and other invested assets	$ 10,639,856,113	$ 10,587,536,353	$ 3,034,780,384	$ 7,262,631,956	$ 342,443,773	$ -

	2016					
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 1,597,906,079	$ 1,615,198,857	$ 776,766,961	$ 821,139,117	$ -	$ -
State and agency municipal securities	686,611,536	689,153,691	-	686,611,536	-	-
City and county municipal securities	808,790,307	811,521,863	-	808,790,307	-	-
Corporate bonds (includes commercial paper)	4,214,163,747	4,188,730,047	-	4,091,852,521	122,311,226	-
Money-market funds	1,511,420,118	1,511,420,118	1,511,420,118	-	-	-
Other invested assets	160,737,401	160,737,401	-	-	160,737,401	-
Mutual funds	27,845,072	27,845,072	27,845,072	-	-	-
Unaffiliated common stock	317,956,351	317,956,351	317,956,351	-	-	-
Preferred stock	16,346,251	14,952,718	-	16,346,251	-	-
Total bonds, short-term investments, mutual funds, unaffiliated common stock, preferred stock and other invested assets	$ 9,341,776,861	$ 9,337,516,118	$ 2,633,988,502	$ 6,424,739,732	$ 283,048,627	$ -

Included as Level 1 in U.S. government and agency securities in the fair value hierarchy tables above are U.S. Treasury securities of $908,396,817 and $776,766,961 as of December 31, 2017 and December 31, 2016, respectively.

Included as Level 2 in corporate debt securities in the fair value hierarchy tables above are commercial paper investments of $23,062,498 and $91,341,269 as of December 31, 2017 and December 31, 2016, respectively. The commercial paper investments reflected in the tables above are included in short-term investments in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

D. Not Practicable to Estimate Fair Value—Not applicable.

21. OTHER ITEMS

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2017 and 2016.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2017 and 2016.

C. Other Disclosures

The Company does not have any amounts not recorded in the statutory basis financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2017 and 2016.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments as of December 31, 2017. Direct exposure through other investments for December 31, 2016 is as follows:

	2016			
	Actual Cost	Book/ Adjusted Carrying Value (Excluding Interest)	Fair Value	Other-than-Temporary Impairment Losses Recognized
a. Residential mortgage-backed securities	$ 1,647,658	$ 1,810,519	$ 2,240,835	$ -
b. Commercial mortgage-backed securities	-	-	-	-
c. Collateralized debt obligations	-	-	-	-
d. Structured securities	-	-	-	-
e. Equity investment in SCAs	-	-	-	-
f. Other assets	-	-	-	-
g. Total	$ 1,647,658	$ 1,810,519	$ 2,240,835	$ -

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2017, the Company is not aware of any possible proceeds of insurance-linked securities.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through May 8, 2018, which is the date these statutory basis financial statements were available for issuance.

TYPE I—Recognized Subsequent Events:

There are no events subsequent to December 31, 2017, that require recognition and disclosure.

TYPE II—Non-Recognized Subsequent Events

The Company is subject to the annual fee under section 9010 of the ACA. This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of the health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, of the year the fee is due. As of December 31, 2017, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2017, and estimates its portion of the annual health insurance industry fee payable on September 30, 2018 to be $807,056,895. This amount has been apportioned out of unassigned surplus and is reflected as Section 9010 ACA subsequent fee year assessment the statutory basis financial statements. In accordance with the 2017 HIF moratorium, no amounts were required to be apportioned out of unassigned surplus/deficit in 2016 (see Note 1). This amount is reflected in Section 9010 ACA subsequent fee year assessment. The Company's Authorized Control Level RBC ("ACL RBC") ratio was 472% as of December 31, 2017. Reporting the ACA assessment as a liability as of December 31, 2017 would not have triggered an RBC action level. The Department has not adopted the NAIC's risk based capital ("RBC") model as a part of its minimum capital requirements.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2017 and 2016:

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (Yes/No)?	Yes	
B. ACA fee assessment payable for the upcoming year	$ 807,056,895	$ -
C. ACA fee assessment paid	-	528,090,540
D. Premium written subject to ACA 9010 assessment	37,883,477,819	
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	6,784,990,282	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	5,977,933,387	
G. Authorized Control Level (Five-Year Historical Line 15)	1,436,352,532	
H. Would reporting the ACA assessment as of December 31, 2017, have triggered an RBC action level (Yes/No)?	No	

On March 26, 2018, with the acknowledgement of the Department, the Company paid an ordinary cash dividend of $750,000,000 to UHIC.

There are no other events subsequent to December 31, 2017 that require disclosure.

23. REINSURANCE

Reinsurance Agreements—In the normal course of business, the Company seeks to reduce potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with affiliated (see Note 10) and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company is subject to the reinsurance provisions pursuant to the ACA for compliant individual policies (see Note 24).

The effect of both internal (see Note 10) and external reinsurance agreements outlined above on premiums for life and accident and health contracts—net and benefits under life and accident and health insurance contracts—net is presented below:

	2017	2016
Premiums for life and accident and health contracts:		
Direct	$49,844,290,637	$43,200,650,021
Assumed:		
Affiliate (Note 10)	2,680,614,788	2,380,976,227
Nonaffiliate	147,091,209	129,458,651
Ceded:		
Affiliate (Note 10)	(109,269,172)	(104,656,505)
Nonaffiliate	(2,024,118,697)	(1,227,274,313)
Premiums for life and accident and health contracts—net	$50,538,608,765	$44,379,154,081
Benefits under life and accident and health insurance contracts:		
Direct	$40,076,332,144	$34,231,443,345
Assumed:		
Affiliate (Note 10)	2,241,667,952	1,897,595,694
Nonaffiliate	131,613,058	115,283,008
Ceded:		
Affiliate (Note 10)	(99,542,920)	(93,786,078)
Nonaffiliate	(1,797,486,039)	(1,104,094,257)
Benefits under life and accident and health insurance contracts—net	$40,552,584,195	$35,046,441,712

Effective July 1, 2016, the Company entered into a quota-share reinsurance agreement with Canada Life (see Note 1). Under this agreement, the Company recognized ceded premiums of $1,862,278,668 and $1,104,080,331 for the years ended December 31, 2017 and 2016, respectively, which are netted against premiums for life and accident and health contracts—net, ceded medical benefits and changes in reserves of $1,647,233,145 and $1,000,639,797 for the years ended December 31, 2017 and 2016, respectively, which are netted against benefits under life and accident and health insurance contracts—net, and ceded expenses of $204,828,828 and $98,491,226 for the years ended December 31, 2017 and 2016, respectively, which are reported as commissions and expense allowances on reinsurance ceded, all in the statutory basis statements of operations. In addition, ceded premium payables of $509,233,198 and $987,237,938 are included in other amounts payable on reinsurance at December 31, 2017 and 2016, respectively, reinsurance recoverables for paid losses of $433,102,620 and $817,482,737 are reported as reinsurance at December 31, 2017 and 2016, respectively, and recoverables for ceded expenses and experience refunds of $70,550,580 and $141,820,430 are

reported in reinsurance at December 31, 2017 and 2016, respectively, all in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company also reported $186,019,707 and $166,040,911 as funds held under coinsurance at December 31, 2017 and 2016, respectively, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company recognized ceded premiums related to other external reinsurance agreements of $161,840,029 and $123,193,982 in 2017 and 2016, respectively, which are netted against premiums for life and accident and health contracts—net in the statutory basis statements of operations. The Company recognized reinsurance recoveries related to other external reinsurance agreements of $150,252,893 and $103,454,460 in 2017 and 2016, respectively, which are netted against benefits under life and accident and health insurance contracts—net in the statutory basis statements of operations. Ceded premium payables were $38,257,111 and $29,832,919 for 2017 and 2016, respectively, and are recorded as other amounts payable on reinsurance in the statutory basis statements of admitted assets, liabilities, and capital and surplus. In addition, reinsurance recoverables related to external reinsurance agreements of $36,355,878 and $28,685,558 for paid losses are recorded as reinsurance and $1,278,295 and $237,919 for unpaid losses are recorded as a reduction to contract claims in 2017 and 2016, respectively, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

A. Ceded Reinsurance Report

Section 1—General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2—Ceded Reinsurance Report—Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes (X) No ( )

If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the reporting entity to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the reporting entity may consider the current or anticipated experience of the business reinsured in making this estimate. $0

What is the total amount of reinsurance credits taken, whether as an asset or as a reduction of liability, for these agreements in this statement? $0

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3—Ceded Reinsurance Report—Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2017.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance**—During 2017 and 2016, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance**—There was no commutation of reinsurance in 2017 or 2016.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation**—Not applicable.

E–G. **Affiliated Captive Reinsurers**—Not applicable.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums due to the Company are recorded in premiums and considerations in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to premiums for life and accident and health contracts—net in the statutory basis statements of operations.

C. Pursuant to the ACA, the Company's commercial business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the commercial lines of business. The formula is calculated pursuant to the ACA guidance. The total amount of direct premiums written for the commercial lines of business subject to the retrospectively rated features was $20,279,670,243 and $18,534,297,915, representing 41% and 43% of total direct premiums written as of December 31, 2017 and 2016, respectively.

Pursuant to the ACA, the Company's Medicare business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the Medicare line of business. The formula is calculated pursuant to the ACA guidance. The total amount of direct premiums written for the Medicare line of business subject to the retrospectively rated features was $14,569,836,425 and $10,873,501,395, representing 29% and 25% of total direct premiums written as of December 31, 2017 and 2016, respectively.

The Company has Medicare Part D risk-corridor amounts from CMS, which are subject to a retrospectively rated feature related to Part D premiums. The Company has estimated accrued retrospective premiums related to certain Part D premiums based on guidelines determined by CMS. The formula is tiered and based on the bid medical loss ratio. The amount of Medicare Part D direct premiums written subject to the retrospectively rated feature was $4,289,766,334 and $4,517,249,634 representing, 9% and 10% of total direct premiums written for 2017 and 2016, respectively.

The Company has risk-adjustment amounts from CMS which are subject to a redetermination feature related to Medicare premiums. The Company has estimated premium adjustments for changes to each member's health scores based on guidelines determined by CMS. The total amount of Medicare direct premiums written for which a portion is subject to the redetermination feature was $10,150,864,696 and $6,167,866,616 representing, 20% and 14% of total direct premiums written for 2017 and 2016, respectively. The risk-adjustment amounts from CMS included in net premium income were $822,970,760 and $626,937,359, representing 2% and 1% of total direct premiums written for 2017 and 2016, respectively.

The Company has a contract with AARP and the underwriting results to this contract are recorded as an increase or decrease in the provision for experience rating refunds. If cumulative net losses were to exceed that part of the experience rated refund liability attributable to AARP, the Company would be required to fund the deficit. Any deficit the Company funded could be recovered by underwriting gains in future periods. When the Company entered into the AARP contract, the Company assumed the policy liabilities related to the AARP program and received cash, investments, and premium receivables from the previous insurance carrier equal to the carrying value of those liabilities as of the contract inception date. The amount of the AARP direct premiums written subject to retrospective rating was $9,418,380,263 and $8,974,225,522, representing 19% and 21% of total direct premiums written for 2017 and 2016, respectively.

In addition to Medicare Part D and AARP agreements, the Company has other contracts with retrospective rating features. The amount of premiums subject to retrospective rating was approximately $239,800,733 and $231,689,367, representing 1% of total direct premiums written as of December 31, 2017 and 2016.

During 2017 and 2016, the Company contracted with the federal government through the OPM to administer the FEHBP. The Company is subject to rate adjustments through audits by the OPM. The amount of direct premiums written subject to retrospectively rated features was $99,020,536 and $61,191,012, representing less than 1% of total direct premiums written as of December 31, 2017 and 2016.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial lines of business. The following table discloses the minimum medical loss ratio rebate liability which is included in provision for experience rating refunds in the statutory basis statements of admitted assets, liabilities, and capital and surplus for the years ended December 31, 2017 and 2016:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ 33,835	$ 29,516,813	$ 18,869,942	$6,056,872	$ 54,477,462
(2) Medical loss ratio rebates paid	17,951	32,140,298	17,832,220	-	49,990,469
(3) Medical loss rebates unpaid	15,884	25,599,276	17,968,785	8,395,563	51,979,508
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	9,636,386
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	1,050,954
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	60,564,940
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	2,838	48,702,536	22,265,179	16,448,974	87,419,527
(8) Medical loss ratio rebates paid	18,722	32,844,741	15,703,594	-	48,567,057
(9) Medical loss rebates unpaid	-	41,457,071	24,530,370	24,844,537	90,831,978
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	12,186,480
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	1,453,104
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	101,565,354

E. **Risk-Sharing Provisions of the Affordable Care Act**

(1) The Company has accident and health insurance premiums in 2017 and 2016 subject to the risk-sharing provisions of the ACA.

The ACA imposes fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs—risk adjustment, reinsurance, and risk corridor.

Risk Adjustment—The permanent risk adjustment program, designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers, applies to all non-grandfathered plans not subject to transitional relief in the individual and small group markets both inside and outside of the insurance exchanges. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance—The transitional reinsurance program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations. The transitional reinsurance program was effective from 2014 through 2016 and applied to all issuers of major medical commercial products and third-party administrators. Contributions attributable to enrollees in the ACA compliant individual plans, including program administrative costs, were accounted for as ceded premium and payments received were accounted for as ceded benefit recoveries. The portion of the individual contributions earmarked for the U.S. Treasury was accounted for as an assessment. Contributions made for enrollees in fully insured plans other than the ACA compliant individual plans, including program administrative costs and payments to the U.S. Treasury, were treated as assessments.

Risk Corridors—The temporary risk corridors program, designed to provide some aggregate protection against variability for issuers in the individual and small group markets during the period 2014 through 2016, applied to Qualified Health Plans in the individual and small group markets both inside and outside of the insurance exchanges. Premium adjustments pursuant to the risk corridors program were accounted for as premium adjustments for retrospectively rated contracts.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities and operations:

a. Permanent ACA Risk Adjustment Program	December 31, 2017
Assets—	
1. Premium adjustments receivable due to ACA Risk Adjustment	$ 67,934,759
Liabilities:	
2. Risk adjustment user fees payable for ACA Risk Adjustment	1,163,452
3. Premium adjustments payable due to ACA Risk Adjustment	86,276,111
Operations (revenue & expense):	
4. Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	(363,186)
5. Reported in expenses as ACA risk adjustment user fees (incurred/paid)	1,191,074
b. Transitional ACA Reinsurance Program	
Assets:	
1. Amounts recoverable for claims paid due to ACA Reinsurance	$ 1,450,754
2. Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3. Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
Liabilities:	
4. Liabilities for contributions payable due to ACA Reinsurance—not reported as ceded premium	-
5. Ceded reinsurance premiums payable due to ACA Reinsurance	-
6. Liability for amounts held under uninsured plans contributions for ACA Reinsurance	-
Operations (revenue & expense):	
7. Ceded reinsurance premiums due to ACA Reinsurance	-
8. Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	3,236,422
9. ACA Reinsurance contributions—not reported as ceded premium	-
c. Temporary ACA Risk Corridors Program	
Assets—	
1. Accrued retrospective premium due to ACA Risk Corridors	$ -
Liabilities—	
2. Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
Operations (revenue & expense):	
3. Effect of ACA Risk Corridors on net premium income (paid/received)	(34,243)
4. Effect of ACA Risk Corridors on change in reserves for rate credits	188,534

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1 Receivable	2 (Payable)	3 Receivable	4 (Payable)	5 Receivable	6 (Payable)	7 Receivable	8 (Payable)	Ref	9 Receivable	10 (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium Adjustment Receivable	$ 56,121,581	$ -	$ 62,641,467	$ -	$ (6,519,886)	$ -	$ 7,178,760	$ -	A	$ 658,874	$ -
2. Premium Adjustment (Payable)	-	(83,998,925)	-	(72,451,645)	-	(11,458,280)	-	11,458,280	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	56,121,581	(83,998,925)	62,641,467	(72,451,645)	(6,519,886)	(11,458,280)	7,178,760	11,458,280		658,874	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	5,076,385	-	7,396,000	-	(2,319,615)	-	3,770,369	-	C	1,450,754	-
2. Amounts recoverable for claims unpaid (contra liability)	533,946	-	-	-	533,946	-	(533,946)	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance—not reported as ceded premium	-	(108,699,279)	-	(108,667,827)	-	(31,452)	-	31,452	F	-	-
5. Ceded reinsurance premiums payable	-	(809,825)	-	(841,277)	-	31,452	-	(31,452)	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	5,610,331	(109,509,104)	7,396,000	(109,509,104)	(1,785,669)	-	3,236,423	-		1,450,754	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	112	-	(112)	-	112	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	(188,534)	-	(34,355)	-	(154,179)	-	154,179	J	-	-
3. Subtotal ACA Risk Corridors Program	-	(188,534)	112	(34,355)	(112)	(154,179)	112	154,179		-	-
d. Total for ACA Risk-Sharing Provisions	$ 61,731,912	$ (193,697,563)	$ 70,037,579	$ (181,995,104)	$ (8,305,667)	$ (11,612,459)	$ 10,415,295	$ 11,612,459		$ 2,109,628	$ -

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2017 was adjusted based on the final CMS Summary Report on Transitional Reinsurance Payments and the Permanent Risk Adjustment Transfers for the 2016 Benefit Year. The risk adjustment receivable as of December 31, 2016 utilized paid claims through October 31, 2016. The adjustment to the December receivable balance reflects the true up to final results for the 2016 Benefit Year. Additionally, the published risk adjustment receivable was reduced by the estimated impact of the funds CMS is not expected to collect due to an insolvent carrier in accordance with the CMS published Frequently Asked Questions ("FAQ") on August 14, 2015. Within the FAQ CMS communicated that benefit year risk adjustment payables within a risk pool will be adjusted in a pro rata basis to the extent that CMS is unable to fully collect risk adjustment funds from all carriers.

B. The risk adjustment payable as of December 31, 2017 was adjusted based on the final CMS Summary Report on Transitional Reinsurance Payments and the Permanent Risk Adjustment Transfers for the 2016 Benefit Year. The risk adjustment payable as of December 31, 2016 utilized paid claims through October 31, 2016. The adjustment to the December payable balance reflects the true up to final results for the 2016 Benefit Year.

C. The reinsurance receivable as of December 31, 2017 was adjusted based on the final CMS Summary Report on Transitional Reinsurance Payments and the Permanent Risk Adjustment Transfers for the 2016 Benefit Year. The adjustment to the amounts recoverable for paid claims was driven by the true up to the HHS Reinsurance Program coinsurance rate of 52.9%.

D. The adjustment to the amounts recoverable for claims unpaid reflects the termination of the reinsurance program as all recovery amounts are now known.

E. N/A

F. Reclassification of amounts reported on Line 5 as of prior year end.

G. Reclassification of amounts reported on Line 4 as of prior year end.

H. N/A

I. The adjustment to accrued retrospective premium reflects a true up to actual cash receipts.

J. The decrease in the policy experience rating refund payable was driven by adjustments in the calculation of the Allowable Costs and Target Amounts due to the inclusion of additional months of run-out on claims and premium retroactivity.

(4) The following table discloses risk corridor receivables and payables by risk corridor program year:

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	**Receivable**	**(Payable)**	**Receivable**	**(Payable)**	**Receivable**	**(Payable)**	**Receivable**	**(Payable)**	**Ref**	**Receivable**	**(Payable)**
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ 112	$ -	$ (112)	$ -	$ 112	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	(188,534)	-	(34,355)	-	(154,179)	-	154,179	F	-	-
d. Total for Risk Corridors	$ -	$ (188,534)	$ 112	$ (34,355)	$ (112)	$ (154,179)	$ 112	$ 154,179		$ -	$ -

Explanation of Adjustments

A. In November 2017, CMS released the Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year report. The report shows risk corridor payment and charges calculated for the 2016 year, by state and issuer, and the additional amounts based on risk corridor collections that HHS expects to pay towards the calculated 2014 benefit year payments. This adjustment reflects the additional amount received and recorded as of December 2017.

B. N/A

C. N/A

D. N/A

E. N/A

F. The decreased policy experience rating refund payable was driven by adjustments in the calculation of the Allowable Costs and Target Amounts.

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

	1	2	3	4	5	6
Risk Corridors Program Year	**Estimated Amount to be Filed or Final Amount Filed with CMS**	**Non-Accrued Amounts for Impairment or Other Reasons**	**Amounts Received from CMS**	**Asset Balance (Gross of Non-admissions) (1 - 2 - 3)**	**Non-admitted Amount**	**Net Admitted Asset (4 - 5)**
a. 2014	$ 11,300	$ 9,507	$ 1,793	$ -	$ -	$ -
b. 2015	654,138	654,138	-	-	-	-
c. 2016	3,909,737	3,909,737	-	-	-	-
d. Total (a + b + c)	$ 4,575,175	$ 4,573,382	$ 1,793	$ -	$ -	$ -

25. CHANGE IN INCURRED LOSSES AND LOSS ADJUSTMENT EXPENSES

A. This disclosure only relates to accident and health contracts. The reserve for life contracts and annuity life contracts are included in a separate disclosure (see Note 31). The disclosure for loss adjustment expenses is included in Note 35.

Changes in estimates related to the prior year incurred claims are included in benefits under life and accident and health insurance contracts—net in the current year in the statutory basis statements of operations. The following table summarizes changes in aggregate reserves for accident and health contracts and contract claims for accident and health policies for the years ended December 31, 2017 and 2016:

	2017	2016
Unpaid claim reserves for accident and health and contract claims for accident and health policies at January 1	$4,809,668,355	$4,421,319,421
Incurred benefits related to:		
Current year	40,646,146,135	35,196,086,553
Prior years	(248,117,423)	(311,855,841)
Total incurred	40,398,028,712	34,884,230,712
Paid claims related to:		
Current year	35,311,557,308	30,580,947,154
Prior years	4,215,505,377	3,914,934,624
Total paid	39,527,062,685	34,495,881,778
Unpaid claim reserves for accident and health and contract claims for accident and health policies at December 31	5,680,634,382	4,809,668,355
Active life reserves	610,938,362	598,685,274
Unearned premium reserve	259,817,343	220,412,781
Contracts subject to redetermination	86,276,111	83,909,925
Total aggregate reserves for accident and health and contract claims for accident and health policies	$6,637,666,198	$5,712,676,335

The liability for aggregate reserves for accident and health contracts and contract claims for accident and health policies as of December 31, 2016 was $4,809,668,355. As of December 31, 2017 $4,215,505,377 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years are now $346,045,555 as a result of re-estimation of unpaid claims. Therefore, there has been $248,117,423 favorable prior year development since December 31, 2016 to December 31, 2017. The primary drivers of favorable development include better than expected actual claims experience, and changes to provider settlement reserves. At December 31, 2016, the Company recorded $311,855,841 of favorable development related to insured events of prior years' primarily as a result of ongoing analysis of loss development trends and changes to the provider settlement reserves. Original estimates are increased or decreased as additional information becomes known regarding individual claims, including the medical loss rebate accrual. Included in this favorable development is the impact related to retrospectively rated policies, which also has a corresponding impact on medical loss ratio rebates. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies, and the impact of the change is included as a component of premiums for life and accident and health contracts—net in the statutory basis statements of operations.

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of aggregate reserve for accident and health contracts and contract claims for accident and health policies in 2017.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2017 or 2016.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2017 or 2016.

28. HEALTH CARE AND OTHER AMOUNTS RECEIVABLE

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Certain Health Care Receivables and Receivables under Government Insured Plans* ("SSAP No. 84") from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2017	$1,416,563,503	$ -	$ -	$ -	$ -
9/30/2017	1,432,577,022	1,404,662,537	835,085,901	-	-
6/30/2017	1,452,250,149	1,456,242,733	1,070,104,169	325,687,312	-
3/31/2017	1,413,382,828	1,412,899,581	714,646,415	563,139,823	106,047,451
12/31/2016	1,322,462,236	1,317,897,458	992,033,740	258,185,710	52,397,460
9/30/2016	1,399,689,893	1,381,413,978	1,039,719,685	282,275,113	45,654,871
6/30/2016	1,375,893,308	1,367,594,870	1,138,614,464	185,873,038	33,892,272
3/31/2016	1,361,149,840	1,343,260,112	1,066,011,802	253,692,118	23,018,189
12/31/2015	1,369,945,995	1,376,022,231	1,180,032,976	180,590,885	4,250,769
9/30/2015	1,348,922,704	1,349,172,953	1,187,132,272	118,727,735	41,339,510
6/30/2015	1,289,523,861	1,306,011,416	1,119,369,452	151,348,186	33,385,355
3/31/2015	1,191,614,249	1,187,232,297	923,884,391	225,815,171	41,708,636

Of the amount reported as health care and other amounts receivable, $1,924,627,422 and $1,848,853,376 relates to pharmacy rebates receivable as of December 31, 2017 and 2016, respectively. This increase is primarily due to increased membership along with the change in generic/name brand mix. An additional $42,930,230 and $12,212,803 of pharmacy rebate ASO receivable is included in amounts receivable relating to uninsured plans as of December 31, 2017 and 2016, respectively.

B. The Company does not have any risk-sharing receivables.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2017 or 2016.

30. PREMIUM DEFICIENCY RESERVES

The Company has not recorded any premium deficiency reserves as of December 31, 2017 or 2016. The analysis of premium deficiency reserves was completed as of December 31, 2017 and 2016. The Company did consider anticipated investment income when calculating the premium deficiency reserves.

The following table summarizes the Company's premium deficiency reserves as of December 31, 2017 and 2016:

	2017
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2017
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2016
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2016
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

31. RESERVES FOR LIFE CONTRACTS AND ANNUITY CONTRACTS

(1–6) The Company's group term life insurance may include a portability option in the policy, whereby an eligible employee may continue coverage as part of a group policy, rather than conversion to an individual policy. For policies under the portability provision, basic, deficiency, and conversion reserves are established. Basic and conversion reserves are based on the Commissioners 1980 Standard Ordinary Mortality ("1980 CSO") table at 4% interest, utilizing permissible select and ultimate factors. The basic reserve is developed as the present value of future benefits minus the present value of future valuation net premiums. The deficiency reserves are based on the premium deficiency that develops from calculation of a net level premium using the 1980 CSO, compared to billed premiums in force on the policies. The conversion reserve develops from comparison of experience mortality from a similar block of policies with a 100% margin added for conservatism to actual expected claims. There are no surrender values associated with these products.

Reserves for premium waivers for individuals who have become disabled and for whom the Company will provide group life insurance coverage without charge are calculated in accordance with the 1970 Intercompany Disability Table for disabilities occurring prior to January 1, 2009, and the 2005 SOA Group Term Life Waiver of Premium Table for disabilities occurring on or after January 1, 2009.

Tabular Interest has been determined by formulas as prescribed by the NAIC. The Tabular Less Actual Reserve Released has been determined by formula as prescribed by the NAIC. Tabular Cost has been determined by a formula as prescribed by the NAIC.

32. ANALYSIS OF ANNUITY ACTUARIAL RESERVES AND DEPOSIT-TYPE LIABILITIES BY WITHDRAWAL CHARACTERISTICS

A–E. At December 31, 2017 and 2016, total annuity actuarial reserves, deposit-type contract funds, and other liabilities without life or disability contingencies by withdrawal characteristics are as follows:

	2017				
	General Account	Separate Account with Guarantees	Separate Account Nonguaranteed	Total	% of Total
Subject to discretionary withdrawal:					
(1) With fair value adjustment	$ -	$ -	$ -	$ -	- %
(2) At book value less current surrender charge of 5% or more	-	-	-	-	-
(3) At fair value	-	-	-	-	-
(4) Total with adjustment or at fair value (total of 1 through 3)	-	-	-	-	100
(5) At book value without adjustment (minimal or no charge or adjustment)	180,886,671	-	-	180,886,671	-
Not subject to discretionary withdrawal	-	-	-	-	-
C Total (gross: direct + assumed)	180,886,671	-	-	180,886,671	100
Reinsurance ceded	-	-	-	-	-
Total (net) (C) - (D)	$ 180,886,671	$ -	$ -	$ 180,886,671	

	2016				
	General Account	Separate Account with Guarantees	Separate Account Nonguaranteed	Total	% of Total
Subject to discretionary withdrawal:					
(1) With fair value adjustment	$ -	$ -	$ -	$ -	- %
(2) At book value less current surrender charge of 5% or more	-	-	-	-	-
(3) At fair value	-	-	-	-	-
(4) Total with adjustment or at fair value (total of 1 through 3)	-	-	-	-	100
(5) At book value without adjustment (minimal or no charge or adjustment)	190,032,666	-	-	190,032,666	-
Not subject to discretionary withdrawal	-	-	-	-	-
C Total (gross: direct + assumed)	190,032,666	-	-	190,032,666	100
Reinsurance ceded	-	-	-	-	-
Total (net) (C) - (D)	$ 190,032,666	$ -	$ -	$ 190,032,666	

F. A reconciliation of annuity reserves and deposit fund liabilities to Aggregate Reserves for Life Policies and Contracts Exhibit and Deposit Funds and Other Liabilities without Life or Disability Contingencies Exhibit, of the Life, Accident and Health Annual Statement and the corresponding lines in the Separate Accounts Statement, are as follows:

	2017	2016
Life Accident & Health Annual Statement		
1. Exhibit 5, Annuities Section, Total (net)	$ -	$ -
2. Exhibit 5, Supplementary Contracts with Life Contingencies Section, Total (net)	-	-
3. Exhibit 7, Deposit-Type Contracts, Line 14, Column 1	180,886,671	190,032,666
4. Subtotal	180,886,671	190,032,666
Separate Accounts Annual Statement		
5. Exhibit 3, Line 0299999, Column 2	-	-
6. Exhibit 3, Line 0399999, Column 2	-	-
7. Policyholder dividend and coupon accumulations	-	-
8. Policyholder premiums	-	-
9. Guaranteed interest contracts	-	-
10. Other contract deposit funds	-	-
11. Subtotal	-	-
12. Combined Total	$180,886,671	$190,032,666

33. PREMIUM AND ANNUITY CONSIDERATIONS DEFERRED AND UNCOLLECTED

A. Deferred and uncollected group life insurance premiums, gross and net of loading, were as follows:

	2017	
Type	Gross	Net of Loading
(1) Industrial	$ -	$ -
(2) Ordinary new business	-	-
(3) Ordinary renewal	-	-
(4) Credit life	-	-
(5) Group life	3,084,566	3,084,566
(6) Group annuity	-	-
(7) Totals	$ 3,084,566	$ 3,084,566

	2016	
Type	Gross	Net of Loading
(1) Industrial	$ -	$ -
(2) Ordinary new business	-	-
(3) Ordinary renewal	-	-
(4) Credit life	-	-
(5) Group life	5,115,292	5,115,292
(6) Group annuity	-	-
(7) Totals	$ 5,115,292	$ 5,115,292

34. SEPARATE ACCOUNTS

A–C. The Company does not have separate account business as of December 31, 2017 and 2016.

35. LOSS/CLAIM ADJUSTMENT EXPENSES

A. The following table summarizes changes in unpaid CAE for the years ended December 31, 2017 and 2016, which are included in general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus:

	2017	2016
Unpaid claims adjustment expenses—January 1	$ 56,841,783	$ 53,151,798
Incurred claims adjustment expenses related to:		
Current year	1,945,118,476	1,727,820,142
Prior years	(11,873,642)	(15,309,395)
Total incurred	1,933,244,834	1,712,510,747
Paid claims adjustment expenses related to:		
Current year	1,720,366,387	1,514,886,842
Prior years	205,377,908	193,933,920
Total paid	1,925,744,295	1,708,820,762
Unpaid claims adjustment expenses—December 31	$ 64,342,322	$ 56,841,783

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of unpaid CAE in 2017.

Due to the type of business being written with these licenses, the Company has no salvage. As of December 31, 2017 and 2016, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of incurred but not yet reported claims.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2017
(To Be Filed by April 1)

Of The UnitedHealthcare Insurance Company

ADDRESS (City, State and Zip Code) Hartford , CT 06103-3408

NAIC Group Code 0707 NAIC Company Code 79413 Federal Employer's Identification Number (FEIN) 36-2739571

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 19,617,542,351

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	UHC Liquidity Pool	Bonds	$ 1,713,344,414	8.7 %
2.02	Oxford Health Insurance, Inc Common Stock	Common Stocks	$ 1,330,995,844	6.8 %
2.03	UnitedHealthcare Ins Co of NY Common Stock	Common Stocks	$ 508,244,710	2.6 %
2.04	FNMA	Bonds	$ 503,218,919	2.6 %
2.05	FHMLC	Bonds	$ 401,906,842	2.0 %
2.06	UnitedHealthcare Ins Co of IL Common Stock	Common Stocks	$ 153,938,828	0.8 %
2.07	UnitedHealthcare of New Mexico, Inc Common Stock	Common Stocks	$ 121,263,991	0.6 %
2.08	Wellington Trust Company	Other Invested Assets	$ 62,745,518	0.3 %
2.09	California ST	Bonds	$ 61,813,316	0.3 %
2.10	Goldman Sachs GP	Bonds	$ 59,596,339	0.3 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 8,256,812,939	42.1 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 1,127,731,736	5.7 %	3.08	P/RP-2	$ 12,945,386	0.1 %
3.03	NAIC-3	$ 381,797,070	1.9 %	3.09	P/RP-3	$ 2,536,872	0.0 %
3.04	NAIC-4	$ 197,780,020	1.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 331,887	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 930,260,899	4.7 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

SUPPLEMENT FOR THE YEAR 2017 OF THE UnitedHealthcare Insurance Company

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 909,759,258	4.6 %
5.02	Countries designated NAIC-2	$ 19,329,683	0.1 %
5.03	Countries designated NAIC-3 or below	$ 1,171,958	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: CAYMAN ISLANDS	$ 237,291,316	1.2 %
6.02	Country 2: UNITED KINGDOM	$ 125,628,910	0.6 %
	Countries designated NAIC - 2:		
6.03	Country 1: MEXICO	$ 10,109,148	0.1 %
6.04	Country 2: ITALY	$ 7,102,261	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1: CYPRUS	$ 831,070	0.0 %
6.06	Country 2: SOUTH AFRICA	$ 340,888	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	UBS GROUP FUNDIN	1	$ 25,707,656	0.1 %
10.02	RABOBANK	1	$ 21,961,212	0.1 %
10.03	Barclays Bank PLC	2	$ 21,088,447	0.1 %
10.04	BP CAPITAL PLC	1	$ 20,697,696	0.1 %
10.05	NATIXIS NY	1	$ 19,000,000	0.1 %
10.06	SUMITOMO MITSUI TR BANK	1	$ 17,779,520	0.1 %
10.07	HSBC HOLDINGS	1	$ 17,493,019	0.1 %
10.08	SVENSKA HANDELSBANKEN NY	1	$ 15,937,449	0.1 %
10.09	ING BANK NV	1	$ 15,560,405	0.1 %
10.10	SOCIETE GENERALE	1	$ 14,873,632	0.1 %

SUPPLEMENT FOR THE YEAR 2017 OF THE UnitedHealthcare Insurance Company

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02	Oxford Health Insurance, Inc Common Stock	$ 1,330,995,844	6.8 %
13.03	UnitedHealthcare Ins Co of NY Common Stock	$ 508,244,710	2.6 %
13.04	UnitedHealthcare Ins Co of IL Common Stock	$ 153,938,828	0.8 %
13.05	UnitedHealthcare of New Mexico, Inc Common Stock	$ 121,263,991	0.6 %
13.06	PIMCO Emerging Local Bond Fund	$ 32,133,011	0.2 %
13.07	Unimerica Life Ins Co of New York Common Stock	$ 21,264,791	0.1 %
13.08	Nike, Inc. Common Stock	$ 10,589,840	0.1 %
13.09	UNITED PARCEL Common Stock	$ 10,440,400	0.1 %
13.10	MICROSOFT CORP Common Stock	$ 10,171,476	0.1 %
13.11	PEPSICO INC Common Stock	$ 9,803,220	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
		1	2	3	4	5	6
		Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1.	Bonds:						
	1.1 U.S. treasury securities	871,389,081	6.316	871,389,081	0	871,389,081	6.316
	1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
	1.21 Issued by U.S. government agencies	203,873	0.001	203,873	0	203,873	0.001
	1.22 Issued by U.S. government sponsored agencies	66,359,585	0.481	66,359,585	0	66,359,585	0.481
	1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	25,720,282	0.186	25,720,282	0	25,720,282	0.186
	1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
	1.41 States, territories and possessions general obligations	237,422,142	1.721	237,422,142	0	237,422,142	1.721
	1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	225,164,580	1.632	225,164,580	0	225,164,580	1.632
	1.43 Revenue and assessment obligations	1,265,870,491	9.175	1,265,870,491	0	1,265,870,491	9.175
	1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
	1.5 Mortgage-backed securities (includes residential and commercial MBS):						
	1.51 Pass-through securities:						
	1.511 Issued or guaranteed by GNMA	34,965,310	0.253	34,965,310	0	34,965,310	0.253
	1.512 Issued or guaranteed by FNMA and FHLMC	849,256,415	6.155	849,256,415	0	849,256,415	6.155
	1.513 All other	0	0.000	0	0	0	0.000
	1.52 CMOs and REMICs:						
	1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	31,331,367	0.227	31,331,367	0	31,331,367	0.227
	1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	313,048,860	2.269	313,048,860	0	313,048,860	2.269
	1.523 All other	0	0.000	0	0	0	0.000
2.	Other debt and other fixed income securities (excluding short-term):						
	2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	3,161,254,107	22.912	3,161,254,107	0	3,161,254,107	22.912
	2.2 Unaffiliated non-U.S. securities (including Canada)	966,949,484	7.008	966,949,484	0	966,949,484	7.008
	2.3 Affiliated securities	0	0.000	0	0	0	0.000
3.	Equity interests:						
	3.1 Investments in mutual funds	32,133,011	0.233	32,133,011	0	32,133,011	0.233
	3.2 Preferred stocks:						
	3.21 Affiliated	0	0.000	0	0	0	0.000
	3.22 Unaffiliated	15,482,258	0.112	15,482,258	0	15,482,258	0.112
	3.3 Publicly traded equity securities (excluding preferred stocks):						
	3.31 Affiliated	0	0.000	0	0	0	0.000
	3.32 Unaffiliated	380,906,142	2.761	380,906,142	0	380,906,142	2.761
	3.4 Other equity securities:						
	3.41 Affiliated	2,135,708,164	15.479	2,135,708,164	0	2,135,708,164	15.479
	3.42 Unaffiliated	0	0.000	0	0	0	0.000
	3.5 Other equity interests including tangible personal property under lease:						
	3.51 Affiliated	0	0.000	0	0	0	0.000
	3.52 Unaffiliated	0	0.000	0	0	0	0.000
4.	Mortgage loans:						
	4.1 Construction and land development	0	0.000	0	0	0	0.000
	4.2 Agricultural	0	0.000	0	0	0	0.000
	4.3 Single family residential properties	0	0.000	0	0	0	0.000
	4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
	4.5 Commercial loans	0	0.000	0	0	0	0.000
	4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5.	Real estate investments:						
	5.1 Property occupied by company	291,612,782	2.114	291,612,782	0	291,612,782	2.114
	5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
	5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6.	Contract loans	0	0.000	0	0	0	0.000
7.	Derivatives	0	0.000	0	0	0	0.000
8.	Receivables for securities	22,099,551	0.160	22,099,551	0	22,099,551	0.160
9.	Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10.	Cash, cash equivalents and short-term investments	2,659,390,297	19.275	2,659,390,297	0	2,659,390,297	19.275
11.	Other invested assets	211,014,900	1.529	211,014,900	0	211,014,900	1.529
12.	Total invested assets	13,797,282,683	100.000	13,797,282,683	0	13,797,282,683	100.000

EXHIBIT III:
SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA—STATUTORY BASIS

UNITEDHEALTHCARE INSURANCE COMPANY

SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA—STATUTORY BASIS AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2017

The following is a summary of certain financial data included in other exhibits and schedules and utilized by actuaries in the determination of reserves:

INVESTMENT INCOME EARNED:	
U.S. government bonds	$ 14,216,400
Other bonds (unaffiliated)	176,696,757
Preferred stocks (unaffiliated)	841,135
Common stocks (unaffiliated)	10,682,628
Common stocks of affiliates	306,800,000
Real estate	17,854,590
Cash, cash equivalents and short-term investments	25,119,250
Other invested assets	(14,163,495)
GROSS INVESTMENT INCOME	$ 538,047,265
OTHER LONG TERM ASSETS—Statement value	$ 502,627,682
BONDS AND STOCKS OF PARENTS, SUBSIDIARIES, AND AFFILIATES (statutory value)	
Bonds	$ -
Preferred stocks	$ -
Common stocks	$2,135,708,164
BONDS, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS BY CLASS AND MATURITY—Bonds by maturity (statement value):	
Due within one year or less	$3,178,627,386
Over one year through five years	3,196,781,081
Over five years through ten years	3,150,252,365
Over ten years through twenty years	287,742,495
Over twenty years	151,050,325
TOTAL BY MATURITY	$9,964,453,652
BONDS AND SHORT-TERM INVESTMENTS BY CLASS—Statement value:	
Class 1	$8,256,812,939
Class 2	1,127,731,736
Class 3	381,797,070
Class 4	197,780,020
Class 5	331,887
TOTAL BY CLASS	$9,964,453,652
TOTAL BONDS PUBLICLY TRADED	$8,708,824,464
TOTAL BONDS PRIVATELY PLACED	$1,255,629,188
PREFERRED STOCKS—Statement value	$ 15,482,258
COMMON STOCKS—Market value	$2,548,747,317
SHORT-TERM INVESTMENTS (BOOK VALUE)	$1,899,064,464
CASH OVERDRAFTS	$ (80,519,432)

UNITED HEALTHCARE INSURANCE COMPANY

SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA—STATUTORY BASIS AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2017

LIFE INSURANCE IN FORCE	
Group life	$66,607,804,636
LIFE INSURANCE POLICIES WITH DISABILITY PROVISIONS IN FORCE	
Group Life	$ 11,888,348
ACCIDENT AND HEALTH INSURANCE—Premiums in force—group	$22,313,386,005
CLAIM PAYMENTS 2017—Group accident and health—year ended December 31, 2017	
2017	$31,529,617,742
2016	27,741,465,574
2015	25,567,971,626
2014	18,575,335,499
2013	20,194,860,093
CLAIM PAYMENTS 2017—Other accident and health—year ended December 31, 2017	
2017	$ 3,781,939,566
2016	2,839,481,580
2015	3,107,453,277
2014	12,103,671,979
2013	11,035,412,937

OTHER ATTACHMENT

Deloitte.

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To the Audit Committee of
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450

The Management of
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450

Dear Members of Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of UnitedHealthcare Insurance Company (the "Company") for the years ended December 31, 2017, and 2016, and have issued our report thereon dated May 8, 2018. In connection therewith, we advise you as follows:

a. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Connecticut Insurance Department, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have 13 years and 6 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 31 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Connecticut Insurance Department and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Connecticut Insurance Department. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the

inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory basis financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Connecticut Insurance Department.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditors' report.

d. We will retain the working papers prepared in the conduct of our audit until the Connecticut Insurance Department has filed a Report of Examination covering 2017, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Connecticut Insurance Department at the offices of the insurer, at our offices, at the Connecticut Insurance Department, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Connecticut Insurance Department, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Connecticut Insurance Department.

e. The engagement partner has served in this capacity with respect to the Company since 2017, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare Insurance Company and for filing with the Connecticut Insurance Department and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

May 8, 2018

The following trademarks and service marks are owned by UnitedHealth Group Incorporated:

Advocate4Me℠	Optum360®	Rally Health℠	UnitedHealthcare®
Algorithms for Effective Reporting and Treatment (ALERT®)	Optum Bank®	SafeTrip™	UnitedHealthcare Health4Me®
American Chiropractic Network (ACN Group®)	OptumHealth®	SimplyEngaged®	UnitedHealthcare® Community & State
Care24®	OptumHealth Financial Services®	Spectera®	UnitedHealthcare® Employer & Individual
Consumer Activation Index®	OptumInsight®	Symmetry®	UnitedHealthcare® Global
EBM Connect®	OptumRx®	UFunding®	UnitedHealthcare® Group Medicare Advantage
Employer eServices®	ParentSteps®	United eServices®	UnitedHealthcare® Medicare & Retirement
eSync®	Passport Connect®	UnitedHealth Allies®	UnitedHealthcare MedicareRx®
eSync Platform®	PlanBien®	UnitedHealth Basics®	UnitedHealthcare Navigate®
GeoNetworks®	Provider Express®	UnitedHealth Group®	UnitedHealthcare Navigate Balanced®
Impact Pro®	Quit For Life®	UnitedHealth Passport®	UnitedHealthcare Navigate Plus®
myuhc.com®	Rally®	UnitedHealth Personal Rewards®	UnitedHealthcare Online®
NexusACO®	Rally Age℠	UnitedHealth Premium®	View360®
OnlinEnroll®	Rally Choice℠	UnitedHealth Wellness®	
Optum®	Rally Engage℠		

The following trademarks are owned by third parties not affiliated with UnitedHealth Group Incorporated:

AARP®	Facebook®	IEX®	NordicTrack®
Adobe®	Gaiam®	iPhone® (iOS)	Nutrisystem®
Android™	GNC®	Jenny Craig®	Polar®
Aperture®	Gold's Gym®	LexisNexis®	Spa Finder®
CAHPS®	Healthwise®	Mastercard®	TotalView®
Curves®	HEDIS®	MCG™	Windows® Phone